

THE MEDICAL AND SURGICAL REPORTER

No. 1629.

PHILADELPHIA, MAY 19, 1888.

VOL. LVIII.—No. 20.

CLINICAL LECTURE.

CRETINISM: CASES PRESENTING TREMOR AS A SYMPTOM WITH THE EXHIBITION OF A PATIENT SHOWING SYMPTOMS OF PARALYTIQUE MULTIPLEX.

BY JAMES HENDRIE LLOYD, M.D.,
PHYSICIAN TO THE PHILADELPHIA HOSPITAL AND INSTRUCTOR IN ELECTRO-THERAPEUTICS IN THE UNIVERSITY OF PENNSYLVANIA.

Reported by William H. Morrison, M.D.

GENTLEMEN: In the previous lectures which I have had the pleasure of delivering before you, I have dealt entirely with the subject of insanity, which is a failure or perversion of mental power or faculties, the result of change or disease coming on in later life, that is, either in adolescence or adult life. There is another great division of mental impairment which is termed idiocy, and of which we have very marked specimens in this hospital. Idiocy may be defined to be a failure, or more properly a lack of development, of mental faculties dating from a period before birth or previous to the period of normal development of the child's intellectual faculties. All idiots are not necessarily congenital idiots, although the affection must date from early childhood before the brain has become developed.

It is not my intention to attempt to-day to cover such an extensive subject as idiocy. There are many forms, and they have been classified by Dr. Ireland in ten divisions. He speaks of (1) the genicid idiot, that is one born so; (2) of the eclampsic or (3) epileptic form, that is those which exhibit epileptic seizures; (4) the paralytic; (5) traumatic or (6) inflammatory, or those in which the idiocy depends upon some acci-

dent either after birth or at the period of birth. It is important that the general practitioner should remember that in a certain proportion of cases the idiocy is due to accidents during labor, either by prolonged labor, by some resistance in the maternal soft parts, some defect in the pelvic canal, or by the use of the obstetric forceps. I have no doubt that some cases of idiocy are due to the use of the forceps, sometimes unavoidably so. These cases of paralytic or traumatic idiocy are often accompanied, as the name indicates, by paralytic phenomena. There is often hemiplegia, and not infrequently certain abnormalities in the shape of the head, such as flattening of the forehead or crushing in of the side of the head. I have seen several such instances. We have next, according to Dr. Ireland's classification, the (7) microcephalic and the (8) hydrocephalic types of idiocy. The first form in which the head is smaller than normal is always congenital. Any case in which the circumference is less than eighteen inches is regarded as microcephalic. Some, in fact, go far below this, even as low as thirteen inches. The appearance of these cases is very characteristic. You have all seen instances of the hydrocephalic idiot, although all patients with hydrocephalus are not necessarily idiots. We next have (9) idiots by deprivation of the senses; that is, those born without the ordinary avenues of sensation. One of the most interesting examples of this group was Laura Bridgeman, whose case was described by Dickens. She was deaf, dumb and blind. She was, however, carefully educated by her instructor. I think that she was, properly speaking, not an idiot. We have then (10) the last division. These are the cretins and cretinoid idiots, and it is to this class that I wish to call particular attention.

Cretinism.

It so happens that we have in this hospital one of the best illustrations of the cretinoid idiot which it is possible to find on this continent, where pure cretinism is not endemic, and where we have only occasional sporadic cases. This man, for so he is, although no taller than a child of four or five years of age, is 29 years old, and has been an inmate of this hospital for many years. With reference to cretinism, it presents certain very distinct and special characteristics which are not found in other forms of idiocy. As you all know there is a form of this affection known as endemic cretinism, found especially in certain mountainous regions, as the Alps and Pyrenees in Europe, and the Cordilleras mountains in this hemisphere. We have practically nothing of it in the United States. Cretins as found in the Alpine villages are, in their worst forms, not unlike the individual before us. The cretin is stunted in stature, he is very deficient in intellect, he usually has a much enlarged thyroid gland, which is not the case in this instance, and he has a peculiar and typical physiognomy which we see to a certain extent in this case. The bridge of the nose is much sunken in and the nostrils flattened out; the eyes are widely separated, with an almost translucent appearance of the structures about the eyes. The lips are thick and large, the mouth constantly open, the hypertrophied tongue protrudes. There is also a tendency to slobber. Cretins also have a peculiarly white or rather a waxy appearance of the skin. The skin is apt to be hypertrophied and scaly. The hands are large, flabby and spade-like. The abdomen is protuding. The sexual apparatus is often undeveloped. The limbs are very short and covered with poorly-developed muscles. There are all degrees of endemic cretinism, varying from a severe form up to one in which there are very slight evidences of the dyscrasia.

There are several interesting questions connected with this subject, especially with reference to goitre and that peculiar condition known as myxedema. This is a very obscure subject on which I am able to throw very little light. I can only indicate what is known about it. These cases of endemic cretinism as seen in mountainous regions are usually accompanied with enlargement of the thyroid gland. We have also cases of sporadic cretinism, of which this case is an example, as he was born in Philadelphia, in which the enlargement of the thyroid gland is usually absent. There is in fact in most of the sporadic cases, no evidence of the

presence of a thyroid gland. I suppose that in the present instance not a vestige of the thyroid gland would be found on dissection. There are, however, certain accumulations of tissue over the clavicles which form distinct masses and are very characteristic of sporadic cretinism. The condition known as as myxedema is allied to cretinism. It is a hypertrophy of the subcutaneous connective tissue in the meshes of which is a product known as mucin. There has been observed a certain relation between this condition of myxedema and enlargement of the thyroid gland. They, as it were, counter-balance one another. Where there is enlargement of the thyroid gland, it seems as though the whole force of the dyscrasia was spent in this way, whereas in cases in which there is not this hypertrophy, the condition myxedema is present. This is of much practical importance especially to surgeons. It was discovered sometime ago by Horsley, of London, that if the thyroid glands of monkeys are removed, a condition of myxedema is likely to appear, and the animals also present the characteristic cretinoid physiognomy. What the relation between these two conditions is, has not been thoroughly elucidated; I can only state the facts. As I have said this is of importance to the surgeon, who is sometimes called upon to extirpate the thyroid gland. I do not know whether or not the destruction of the gland by galvanic puncture would tend to induce this condition of myxedema. It would, however, be a great misfortune for the patient to exchange her goitre for a condition of myxedematous degeneration.

Very little is known with reference to the true pathology of cretinism. There are, however, one or two views brought forward by those who have especially investigated the subject, and to these I wish briefly to call attention. It is found on dissection in all cases of cretinism, that they present to a marked degree what is known as basilar synostosis, that is to say, early ossification of the cartilage, which normally exists in early life between the body of the sphenoid bone and the basilar process of the occipital bone.

I shall next call attention to one or two features presented by this case. The enlargements over the clavicles are very characteristic. You note the coarse hair, the widely separated eyes, the large increase of tissue about the eyes, the thick lips and constantly protruding tongue. The man's eyesight is very poor; his intelligence is very low, but he probably knows more than we would give him credit for from his appearance. He shows often to those familiar with him that

he does take notice and does remember. You observe the protruding abdomen, and the small, crooked legs. He can walk a little, but he does not do it unless compelled to. His sexual organs are those of a boy three or four years old. Another feature is his utterly apathetic condition, the purely vegetative life which he leads. As you see him here, so he sits all day long. He interests himself in nothing, and requires nothing to amuse him. He has very few accomplishments; the only two which I recall are that he can swear like a tramp and kiss his hand to the ladies. His range of words is limited, but he seems to understand most that is said to him.

One more word with reference to the anatomical condition in this affection. It is almost invariably, if not invariably, found that there is this premature synostosis or alteration in the cartilage between the body of the sphenoid and the basilar process of the occipital bone, and it has been supposed that this is the cause of this peculiar state. Whether or not this is the case, we cannot be positive. It was Virchow, I believe, who originally demonstrated the existence of this anatomical condition. It is conjoined with premature ossification of the epiphyses of the long bones, helping to produce the dwarfed condition of the limbs, which is seen in cretinism.

Cases Presenting Tremor as a Symptom with the Exhibition of a Patient Showing Symptoms of Paroxysmal Multiplex.

I shall now call your attention to certain forms of tremor and myoclonic disorder—a very wide and interesting subject. The whole subject of tremor, ataxia, irregular spasm, and local convulsion unaccompanied with loss of consciousness, presents numerous difficulties to clinical pathological study. We have succeeded in differentiating certain varieties of these into well-marked forms of disease. For instance we have the pure and simple chorea, the chorea of childhood, the disease known as Sydenham's chorea, which can usually be diagnosed without difficulty. We have, however, other forms, approaching the choreic form which are not so easily diagnosed, and the pathological conditions underlying which present many difficulties and mysteries. Besides chorea, there are some other forms of motor disorder which are not difficult to recognize. Among these we have Parkinson's disease or paralysis agitans. Then we have tremor depending upon change in the nervous structures, which is

termed disseminated sclerosis or sclerosis in plaques.

The three patients now before you represent to a certain extent these three forms of motor disorder. The first case can be dismissed with a very few words. This woman is suffering with paralysis agitans, an affection which was first described by Parkinson in 1817. I want you to note that the arms and limbs, and the forearms more especially, are in a condition of constant tremor, which presents certain characteristics not seen in any other form of tremulous disorder. In the first place the tremor is constant during the absence of voluntary motion. The character of the tremor also is peculiar, and has not I think been sufficiently dwelt upon in considering the differential diagnosis of these cases. There is a distinct rhythmical movement of the forearms, which is dependent upon alternate action of the flexors and extensors. This movement is gentle, limited in range and not incoördinate. In the earlier stages of this affection, and usually only in the early stages, the patient is able to control this spasmodic condition by voluntary movement. This is mentioned by many as one of the diagnostic points, but it does not hold in all cases, and especially is this true in the advanced cases. It is usually stated that patients suffering with paralysis agitans are able to write, that when the voluntary impulse is sent out through the nerves, the muscles are steadied and for a short time the spasm is stopped. In the present case the attempt to write has very little effect on the spasmodic movements.

This second case is interesting for two or three reasons. This man is afflicted with irregular spasms of the muscles of the face, neck, trunk, arms and legs. These spasmodic contractions are wide in range, causing the patient to gesticulate, squirm and grimace in a grotesque and conspicuous manner. He has but little control over these motions; and they continue incessantly during the absence of voluntary movement. If you saw a child of ten years of age exhibiting such movements, you would at once say that it was a case of chorea. This patient, however, is rather more advanced in years than is usual for the development of chorea. There is also a distinct family history of this disorder. You notice the difference between the movements of this man and those of the woman to whom I have called attention. She has the constant rhythmical spasms of paralysis agitans; he has the incoördinate action of the muscles of the arms known as chorea. I might state here that in paralysis agitans, the muscles of the neck are

rarely involved. The tremulous motion of the head is due to the shaking of the body from the tremor of the extremities. In this man there is marked movement of the muscles of the neck. We have tried to reach some other diagnosis in this case than chorea. I thought at one time that there was a degree of ataxia which might warrant a diagnosis of one of the ataxic states. I am now inclined to think that it is a case of chorea, depending in some peculiar way upon hereditary taint. What that is I am unable to say. I do not recall having ever heard such a distinct family history of chorea as this man gives us. The patient tells us that his grandfather, and two of his father's brothers had this condition. One paternal aunt suffered in the same way. His aunt married and raised a family of children before the trouble appeared. The patient's father died young, and never suffered with this affection. As far as the patient knows, none of the family had fits. He, himself, never had chorea when young so far as I am able to determine. His present age is 43 years, and the trouble began seven years ago.

This case presents decided distinctions from the ordinary chorea of childhood. Chorea of childhood is not an hereditary affection. As you have heard this man has given a distinct history of the affection coming on in other members of the family in adult life. The patient was himself 36 years of age when the disease appeared. This condition seems not to be amenable to treatment. He has been given the ordinary specific remedies for chorea without effect. What underlies this condition is a subject for speculation. It was at one time thought that this might be a case of what is known as Friedreich's disease, which affection might be called hereditary locomotor ataxia. It comes on within a few years after birth and consists of a congenital lack of development, producing early degeneration of the lateral tracts together with the posterior columns of the cord. This leads to a form of ataxia not unlike locomotor ataxia. Such cases, however, do not have the lancinating pains and the lesions of sensation that are seen in locomotor ataxia. This patient evidently does not belong to this class.

This colored boy, the last case which I shall show you, is by far the most interesting of all. In the effort to differentiate these conditions, there has been mapped out by neurological writers a certain indistinct type of disease which has been called *para-myoclonus multiplex*. This term means a more or less universal clonic spasm of the muscles. This

affection also was first described by Friedreich. I have brought this colored boy before you to-day to serve as a text for a few remarks upon this affection. He presents certain multiplex myoclonic phenomena to a marked degree, although I am disposed to think that there is some organic change in the cord, such as disseminated sclerosis, to account for the condition present. Friedreich described the first case of this disease reported, that of a patient fifty years of age suffering with phthisis, who after a severe shock suffered for some time with a condition of almost tetanic rigidity. This was followed by a condition of clonic spasms in the muscles of the arms, the trunk and the limbs, varying in rapidity from ten to fifty per minute. These clonic spasms continued more or less persistent until the death of the patient from the disease of the lungs. I believe that at one time they were partially relieved by the galvanic current. Several other observers have since then put on record cases of a similar character. These cases were unassociated with any loss of consciousness. The peculiar clonic conditions have not been exactly alike in all the cases reported, and they probably differ in their causes and pathology. In some the clonic spasms have been paroxysmal. Hammond has described a condition of convulsive tremor, more or less closely allied to this condition, but in which the spasms occur in paroxysms, the patient having immunity for a long period of time. Some of these cases are much worse on voluntary movement, while others are made better. In some of these cases there is associated a more or less tetanic condition.

In the present case there are three distinct forms of movement. As he sits before you, you will notice a choreiform movement of the muscles of the arms and of the trunk, which is constant, and not associated with voluntary movement. There is another variety of movement which is seen in certain forms of mental weakness and imbecility, and also occasionally in hysteria and hypochondriasis, which is a peculiar acquired movement. He has a curious habit of slapping one hand on the other when a little agitated and when talking. Neither of these movements is of the nature of pure myoclonus. When talking you observe that he has one or two set expressions which he always uses. His intellectual capacity is not very great. Every time that he speaks he exhibits this automatic movement of one hand upon the other. This is not choreic.

He has still another interesting form of motor disturbance. When he puts his feet

upon the floor and attempts to walk, his legs are thrown into a more or less tetanic or rigid condition, which is not a true spastic spasm, but consists of a series of clonic contractions of the muscles of the thighs. This is especially well marked when he attempts to sit down. The patellar reflexes are decidedly increased. The slightest tap over the patellar tendon causes a very marked contraction of the quadriceps. There seems to be no ankle-clonus.

The facts which have made the strongest impression upon my mind are that these three types of movement are presented in one case, and that the condition of the lower limbs is the one which is more distinctly related to these multiplex myoclonic phenomena than I have ever seen it before. As in many other cases in this hospital, we have been unable to obtain much history of this patient. As far as we can make out this condition has come on within the last two or three years. It is not associated with other evidences of degeneration of the central nervous system. There are no areas of anaesthesia. The eyes have been examined by Dr. De Schweinitz, and no appreciable alteration in the eye-ground found. I think that in this case, the diagnosis lies between some form of disseminated sclerosis and the motor phenomena described under the head of para-myoclonus multiplex.

In a certain number of cases we have a degeneration of the central nervous system known as disseminated sclerosis or sclerosis in plaques. In this affection there are little islets of degeneration over the cortex, and involving more or less the other structures of the brain and extending downward into the cord. This produces a special alteration of motility which is to be diagnosed from the other conditions already referred to. In this affection we have, especially in the arms, a degree of ataxia which it is necessary to differentiate from *paralysis agitans*. In the latter we have the peculiar rhythmical character of the spasm, and the fact that it is more or less controlled by the will. In disseminated sclerosis we have just the opposite. When the patient attempts to make a voluntary movement the motor impulses passing down the lateral columns of the cord are more or less broken up and interrupted by these islets of degeneration. As a consequence we have a series of spasmodic movements which are more ataxic in character than *choreic*, and which have not the rhythmical character seen in *paralysis agitans*. It so happens that in this form of disseminated sclerosis these islets become more and more

numerous in the cord, and set up in the lateral columns a process of degeneration running down the motor tracts of the cord. The result is that while we still have this condition of ataxic jerking movement in the arms, we are apt to have in the lower limbs a condition of spastic paraplegia. This man has more or less of this condition. He has what is very characteristic of disseminated sclerosis—marked increase in the patellar reflexes. I feel somewhat in doubt about the diagnosis, because in his arms he does not present the characteristic conditions of disseminated sclerosis. He has not the jerking movement of this affection. He has, however, this constant choreiform movement entirely independent of volition. I should call it a case presenting rare multiplex myoclonic symptoms, probably the expression of an insular degeneration in the central nervous system.

COMMUNICATIONS.

TREATMENT OF PLACENTA PREVIA. A HISTORICAL AND CRITICAL SKETCH.¹

BY CHARLES P. NOBLE, M.D.,
SENIOR ASSISTANT PHYSICIAN, PHILADELPHIA LYING-IN
CHARITY.

Placenta previa occurs so rarely that the practitioner is especially dependent upon the literature of the subject for the foundation principles upon which to base successful treatment. The frequency of its occurrence is variously estimated by authors.

Johnson and Sinclair,² of the Rotunda Hospital, gave it as 1 in 573; Schuey,³ 1 in 1564, among 519,328 labors in the Grand Duchy of Hesse; Müller,³ 1 in 1078, based on 876,432 births; Lomer,³ at least 1 in 723 deliveries in Berlin.

The placenta is said to be *previa* "when it is attached to any portion of the uterus which is subject to distention during labor" (Lusk). Placenta previa is central or complete when only placenta can be felt after dilatation of the internal os. It is partial or incomplete, when after dilatation of the os, the membranes as well as the placenta can be felt. It is marginal, when the placental border reaches the internal os; and lateral, when attached within the zone of distention, but where the placental border does not extend to the inner os.

¹ Arranged from a paper read before the Northern Medical Association of Philadelphia, April 13, 1888.

² Playfair, *Sys. Midwif.*, p. 394.

³ Lomer, *Am. Jour. Obstet.*, Vol. XVII, p. 1248.

Lateral implantation is often an unrecognized cause of so-called accidental hemorrhage. The amount of hemorrhage and the mortality vary with the variety of placental insertion. It is generally admitted that the source of hemorrhage in placenta previa is the lacerated utero-placental vessels. Mackenzie¹ in a series of experiments on pregnant bitches, where he partially detached the placenta, demonstrated that the blood flowed from the bared uterine wall, and not from the surface of the placenta. The abandonment of the teaching of Hamilton and Simpson that the source of the hemorrhage was from the partially separated placenta, has greatly influenced modern practice.

Various explanations have been given as to the cause of hemorrhage during pregnancy. The first theory was that obliteration of the cervical canal by being drawn up into the cavity of the body of the womb in the later months caused a spreading out of the internal os, and partial separation of the placental attachments. This was naturally abandoned as being generally applicable, when it was shown that the supposed shortening of the cervical canal did not occur at all, or only in the last weeks of gestation.

The theories of Jacquemier and Barnes as to the relative frequency of growth of the placenta and uterine wall, must likewise be abandoned. For not only are they diametrically opposite, but also they are negatived by the fact that cases of placenta previa frequently go to term without hemorrhage; were either true, hemorrhage would be inevitable during the last three months of pregnancy.

They are further opposed by the admitted observation that placenta previa is a not uncommon cause of abortion. Finally, Matthews Duncan² asserts that the causes are the same as where hemorrhage occurs during gestation with a normal insertion of the placenta; that while its occurrence is favored by the abnormal position of the placenta, it is a purely accidental phenomenon, and in no sense inevitable. This view is favored by the fact that it not uncommonly does not occur till labor at term. Aside from occasional rupture of a vessel, and partial separation of the placenta from blows, jerks and falls, hemorrhage may at any time take place from detachment, brought about by uterine contractions. That intermittent uterine contractions are present from an early period of pregnancy, has been shown by Brax-

ton Hicks,³ and is universally admitted. And as Playfair² observes, "there is no reason to suppose that these contractions do not affect the cervical, as well as the fundal portions of the uterus; and in cases where the placenta is situated partially or entirely over the os, one or more stronger contractions than usual may at any moment produce laceration in that neighborhood." This view is accepted by Spiegelberg and King,³ and certainly best accords with the various conditions.

During labor, hemorrhage is caused by the loss of relation from dilatation of the os and lower uterine segment. But even here it is not inevitable. "Although," says Cazeaux, "hemorrhage is usually considered to be inevitable under such circumstances, yet it may not appear even during labor; and the dilatation of the os uteri may be affected without the loss of a drop of blood." A recent case of my own substantiates this, for while interference was not used until the head was on the perineum, yet the labor was concluded without the loss of blood. Hemorrhage is apt to be less where the fetus has been dead for some time, so that retrograde changes have occurred in the utero-placental vessels. Simpson has shown that where the placenta is expelled before the birth of the child, hemorrhage generally ceases. The investigations of Barnes and Duncan satisfactorily explain these cases. Barnes has demonstrated that separation need only occur for a certain distance within the os; after which, with strong uterine contractions to seal up the mouths of the torn vessels, hemorrhage ceases; that hemorrhage ceases after complete detachment, not because it is complete, but because it is detached from the area of dangerous implantation; that in the cases where hemorrhage is absent, the pains have been sufficiently strong to separate the placenta from the cervical zone before flooding occurs. Strong contractions are necessary to prevent subsequent hemorrhage. Some of these cases may be explained upon the ground that in the region of the os at term, intimate vascular connections do not exist. I am sure that this was true of my case already referred to.

The prognosis is variously stated. It depends largely upon the degree of implantation, and also upon the method of treatment. According to Lusk, one mother out of four dies during or shortly after delivery, and nearly two out of three children are born

¹ Playfair *L. c.*, p. 397.

² Playfair *L. c.*, p. 398.

³ Obstet. Trans., vol. xiii.

⁴ *L. c.*, p. 398.

⁵ *L. c.*, p. 754.

dead
cess
nal
Am
tier
Mül
25 P
better
death
8.5
cent
1 de
Lom
death
cent
mate

T
and
men
thor
cent
age
berg
meier
Muri
per
cent

PL
comp
Porta
Roed
Gree
ment
have
ture

7
no t
comp
the h
in 13
ity w

Ac
meth
livery
throu
which
tracte
cervi
depl

1 L.

2 L.

3 M.

4 P.

5 L.

6 L.

7 L.

8 Rig

from P
tracted
found a

dead. Including deaths from puerperal processes, Müller¹ (1877) estimates the maternal mortality at from 36 to 40 per cent. Among 4,164 cases, collected by Charpentier, Depaul, Simpson, Schwarz, Trask, Müller and King,¹ there were 1,045 deaths—25 per cent. Individual operators have secured better results. Thus: Spiegelberg 102, 16 deaths, 16 per cent.; Barnes 69, 6 deaths, 8.5 per cent.; Hecker 70, 7 deaths, 10 per cent.; Müller 15, no deaths; Hofmeier 37, 1 death, 2.6 per cent.; Behm 40, no deaths; Lomer² 16, no deaths; Murphy³ 23, no deaths; E. Wilson⁴ 30, 2 deaths, 6.6 per cent. Nine operators had 402 cases, 32 maternal deaths, 7.9 per cent.

The prognosis for the child is much worse, and as will appear later, no method of treatment materially improves its chances. Authors give it as follows: Schwarz, 75 per cent.; Barnes, 64 per cent.; Müller (average of 2,360 cases), 64 per cent.; Spiegelberg and Braun, 50 per cent.; Lomer,⁵ Hofmeier and Behm (178 cases), 60 per cent.; Murphy³ (23 cases), 57 per cent.; King,⁶ 57 per cent. (Partial placenta previa, 41 per cent.; complete, 66 per cent.)

Placenta previa has been recognized as a complication of labor since 1685, when Portal wrote on the subject. Levret, Smellie, Roederer, Rigby, Barnes, Braxton Hicks, Greenhalgh, Thomas and Murphy may be mentioned as prominent among those who have contributed to a knowledge of its nature and treatment.

Treatment.—King⁷ reports 33 cases where no treatment was used. In 11, there was complete, in 11, partial placental presentation, and in 11 this was not noted. In 14, the hemorrhage was moderate; in 6, profuse; in 13, not reported. The maternal mortality was 33 per cent.; fetal, 58 per cent.

Accouchement forcé.—One of the oldest methods of treatment is that of forced delivery. One or two fingers were inserted through the os, then the entire hand, after which the fetus was turned and rapidly extracted. Contusions and lacerations of the cervix were inevitable⁸, and the result so deplorable that the method was and is uni-

versally condemned. Müller¹ reports 92 cases of *accouchement forcé* followed by version, with a maternal mortality of 47.8 per cent.; fetal, 62.7 per cent.

Rupture of the Membranes.—This measure was proposed by Puzos. It is claimed for the method that by evacuating the liquor amnii it stimulates the uterus to contract, and thus arrests hemorrhage. It has the endorsement, among other modern authorities, of Barnes and Playfair.

Barnes² says that "the puncture of the membranes is the *first thing* to be done in all cases of flooding sufficient to cause anxiety before labor." But as King,³ Müller and Lomer⁴ have shown, in a considerable percentage of cases, hemorrhage does not cease after the manœuvre—a serious matter where the membranes have been ruptured with an undilated os. It is now difficult or impossible to do combined version. The ovum no longer acts as an internal tampon, and concealed hemorrhage is apt to occur if the vaginal tampon is employed as is advised.⁵ Hemorrhage ceases most often after rupture⁶ of the membranes, in cases of partial or lateral implantation. Shroeder, Cazeaux, King⁶ and Murphy,⁷ advise rupture only after a certain amount of dilatation. Hence, we may conclude that rupture should not be practiced early, except as a step in Braxton Hicks' method. King⁸ reports 24 cases, with a maternal mortality of 8 per cent.; fetal, 42 per cent. Fourteen of these were cases of partial placenta previa, and in only nine was the hemorrhage severe. The two maternal deaths he ascribes to early rupture of the membranes.

The Tampon.—Leroux is usually credited with introducing the tampon treatment in 1776; but according to Parvin,⁹ this author mentions no instance of its use in placenta previa, and to Wigand must be given the honor.¹⁰ Wigand did not use the tampon

¹ Ency. Obstet. and Gyn., Vol. III, p. 222.

² Obstet. Operat., p. 376.

³ L. c., p. 771.

⁴ L. c.

⁵ Playfair, L. c., and Barnes.

⁶ King, L. c., p. 776.

⁷ Murphy, *Med. Press and Circ.*, Vol. II, 1885.

⁸ L. c., p. 771.

⁹ L. c., p. 321.

¹⁰ As bearing upon this point, the following quotation from Rigby's *Midwifery* (The Library of Medicine, by A. Tweedy, Vol. vi., p. 260) is of interest: "If, after the commencement of a flooding we favor the formation of a coagulum by means of a plug, are we not aiding nature? It brings on labor much sooner, and the os uteri has time to dilate without further loss of blood."—(Leroux, *sur les Pertes de Sang*, § 309.)

¹ Lomer L. c., p. 1241.

² L. c., p. 1242.

³ *Medical Press and Circular*, Vol. II, p. 206 (1885).

⁴ Parvin's *Obstet.*, p. 327.

⁵ L. c., p. 1247.

⁶ L. c., p. 750.

⁷ L. c., p. 765.

⁸ Rigby was aware of this, and mentions deaths from post-partum hemorrhage, with a firmly contracted uterus. He says that in these cases Naegele found cervical lacerations, *post mortem*.

exclusively, as exceptions, he says: "It cannot be applied with women whose birth-passage is so irritable that they cannot retain the tampon, even for the space of fifty minutes; so, too, one would act very unreasonably, and even criminally, were he to use the method when called to a woman who had bled almost to death."¹

Wigand states that he saved all the mothers and children where he used the tampon. This statement, together with his references to feeling the bag of waters, would indicate that he was not dealing with cases of central implantation. Certainly no one's results since, have equalled his. The tampon and internal version have been the methods in most general use during this century. Besides the classical tampon the followers of Barnes have used his hydrostatic dilators, which have the advantage of dilating the os while restraining hemorrhage, and the Vienna school under Karl Braun have largely employed his colpeurynter. The colpeurynter is useful to dilate the vagina in primaparæ. The object sought in the use of the tampon is to restrain hemorrhage while the os dilates. The uterine vessels are compressed by the tampon below and the ovum above, and whatever hemorrhage occurs adds to the pressure. The tampon also restrains hemorrhage by exciting uterine contractions. After dilatation is secured, delivery is effected by the natural powers, version, or the forceps. King,² in 75 cases reports a maternal mortality of 25 per cent.; fetal, 53 per cent., although the cases were relatively favorable. Especially where the tampon was followed by version was the result bad—34 cases, 35.7 per cent. maternal mortality; 61.7 per cent. fetal. Charpentier³ reports 65 cases (Parisian clinic), with 35 per cent. maternal mortality. The tampon was followed by spontaneous delivery, version, or the forceps.

Ergot.—This is given by Auvard as the method of Paul Dubois. According to Parvin⁴ the results of this method are a maternal mortality of 42 per cent.; fetal, 77 per cent. But while this is true where ergot is relied upon exclusively, it is not where it is given after dilatation is secured. Murphy⁵ and E. Wilson both use it freely at this time, and together they had fifty-three cases with only 2 maternal and 21 fetal deaths. King's¹ table also shows that ergot is a useful adjuvant.

¹ Parvin, *L. c.*, p. 321.

² *L. c.*, p. 775. The general mortality was only 22 per cent.

³ *L. c.*, p. 220.

⁴ *L. c.*, p. 323.

⁵ *L. c.*, p. 208.

Complete Detachment of the Placenta.—This is usually given the method of Radford and Simpson.¹ It is now purely of historical interest, since the premises upon which it was based have been proved to be false, and also because its maternal, and especially its fetal mortality was high. Simpson in 141 cases gives maternal mortality, 13.6 per cent.; fetal, 79 per cent. But Water and Trask in 94 cases had a maternal mortality of 24 per cent.; fetal, 75 per cent., and Hecker a maternal mortality of 27.5 per cent.² King's³ table in 22 cases of central placenta previa gives a mortality of 18 per cent. and 77 per cent., respectively.

Podalic Version.—Since the days of Portal, until recently, internal podalic version has been resorted to in cases of alarming hemorrhage from placenta previa.⁴ It was a part of the old method of forced delivery, and afterwards was used after the tampon or other method of treatment. Müller⁵ collected 860 cases of internal version with a maternal mortality of 30 per cent. King,⁶ 115 cases, maternal mortality 23 per cent.; fetal, 60 per cent.; in 63 cases version alone was used, mortality 22 per cent.

Forceps.—The forceps do not appear to have been largely used. They can scarcely be applied in the central variety, and dilatation is always a pre-requisite. When used within the uterus, in addition to the recognized dangers of the high operation, there is greater liability to rupture of the inferior uterine segment, from the increased vascularity present, with subsequent hemorrhage. Charpentier mentions 9 cases, with 4 maternal and 6 fetal deaths. King reports 10 cases of which 3 mothers, and 6 children died. It would seem best to reserve the forceps for those cases where the head is in the pelvic cavity, and uterine inertia is present.

The foregoing are the methods which, until recently, have been employed, singly or combined, in the treatment of placenta previa. Including all cases, all varieties of placental presentation, cases in which nature effected the delivery more or less assisted by these measures, and those in which version or the forceps were employed, the maternal

¹ Portal and Smellie both practiced this method.

² Charpentier, *L. c.*, p. 223.

³ *L. c.*, p. 772.

⁴ Portal had excellent results. He details fourteen cases, and lost but one mother. Besides he "had saved divers other women in the same condition in the hospitals in Paris." (Translation *Complete Practice of Men and Women Midwives*, London, 1763.)

⁵ Charpentier, *L. c.*, p. 221.

⁶ *L. c.*, p. 778.

mortal
fetal,
inclu
per c
cond
result

Fix
"Por
ject c
display
uteri,
press
Fortu
that
meth
ture l
and t

Bar
centa
and p
His n
words
Apply
plug
must n
arate
lower
orrhag
its w
If nat
ceps,
child,
sixty-r
8.5 pe
the un
saved
believe
should
delive
uterin
water-

Ind
Dr. R
the O
"Prac
Placem
this p
Drs. I
T. G.
practi
credit
metho
1877,

¹ Edi

² Bri

³ Bri

⁴ Obs

⁵ Both

practice

mortality is at least twenty-five per cent.; fetal, sixty per cent. Müller estimates that, including deaths from puerperal causes, forty per cent. of the mothers die. This mortality condemns the methods, for by others, better results can be obtained.

Fifty years ago Dr. Renton¹ said that "Portal, in 1672, knew as much on the subject of uterine hemorrhage occasioned by the displacement of the placenta from the os uteri, and the practice necessary for its suppression, as we do at the present time." Fortunately this is no longer true. Since that time there have been introduced the methods of Barnes; the induction of premature labor; Braxton Hicks' combined version, and the method of Murphy.

Barnes' Method.—Barnes wrote on placenta previa in 1847-57, and his theories and practice have changed but little since. His method is best described in his own words.² "1. Rupture the membranes. 2. Apply a firm binder over the uterus. 3. A plug may be applied to gain time, but it must not be trusted; watch closely. 4. Separate all the placenta that adheres within the lower zone, and observe closely. If no hemorrhage, wait awhile. The uterus may do its own work; if not dilate the cervix with the water-bags. Again pause and observe. If nature fails to deliver we resort to the forceps, which gives the best chance for the child, or turn." Dr. Barnes has reported sixty-nine cases with a maternal mortality 8.5 per cent.; fetal, 67 per cent. He makes the unfounded claim³ that his method has saved more mothers than any other. We believe that Barnes' greatest claims to notice should be based upon his opposition to forced delivery, his teachings concerning the lower uterine segment, and his introduction of the water-bags.

Induction of Premature Labor.—In 1864, Dr. Robert Greenhalgh read a paper before the Obstetrical Society of London, entitled "Practical Remarks upon the Treatment of Placenta Previa,"⁴ in which he advocated this practice. His views were accepted by Drs. Barnes, Hicks, Hewitt and Oldham. T. G. Thomas, in 1868, advocated the same practice. To these two men belong the credit of systematizing and formulating this method of managing placenta previa.⁵ In 1877, Thomas wrote a paper on the subject,

in which he reported eleven cases, with one maternal death from sepsis. The advantages of the method are obvious. The mother has not been drained of life's fluid by repeated hemorrhages. She is saved the mental agony of fear induced by the fearful floodings that so often occur during the last three months of pregnancy. She is ensured a medical attendant in her hour of need. Above all, her chances for recovery are increased. The infant's prospects, also, as has been amply demonstrated, are conserved by the method. The physician is enabled to have counsel or assistance, and to conduct the labor in an orderly and systematic manner. Labor is best induced by dilatation of the os with Barnes' bags. When dilatation is secured, bi-manual version may be done, or if the presentation is marginal or lateral, the membranes ruptured, and nature, perhaps, assisted by the forceps, left to complete the delivery. With Murphy and Wilson we may give ergot freely after the os is dilated. When called during a hemorrhage the tampon should be used till a consultation decides upon the induction of labor, or if the hemorrhage is severe we may proceed at once with bi-manual version, sufficient dilatation being present to introduce one or two fingers. The only period at which this method may be questioned is before the viability of the child. The results are as follows: Hecker, of 40 women lost but 3, while his general mortality was 10 per cent.; Hoffman, in 33 cases lost 2; Spiegelberg, in 74 cases lost 4, or 5 five per cent., while his general mortality was 16 per cent.; Murphy lost no mothers.¹

Bi-manual Version; the method of Braxton Hicks.—In 1860, Braxton Hicks² read a paper before the London Obstetrical Society on a new method of turning the bi-manual, especially as applied to placenta previa, and reported six cases thus treated. The method was suggested to him by the success of Wigand and his followers in performing version by external manipulations. In the cases reported he turned by the bi-manual method as soon as he could introduce one or two fingers through the os, pulled down a leg as a tampon, and waited. I quote the following from his paper: "I have in all cases narrowly watched for any external or internal hemorrhage without having met with it. * * * Turn, and the danger is over if you employ the child as a plug; wait then for the pains, and let nature, gently

¹ *Edin. Med. and Surg. Journal*, July, 1837.

² *Brit. Med. Journal*, Mar. 3, '88, p. 460 and 461.

³ *Brit. Med. Journal*, March 3, '88.

⁴ *Obstet. Trans.*, Vol. V.

⁵ Both Portal and Baudelocque advocated this practice.

¹ Charpentier and Lomer, *l. c.*

² *Obstet. Trans.*, Vol. V, p. 222.

assisted, complete the delivery."¹ There can be no question that much of the success of Barnes and Murphy has been achieved through the use of this method, for both employ it when they turn. But in Germany it has found its strongest exponents. Hofmeier first tried it. He had 37 cases, with one maternal death. Behm, encouraged by Hofmeier's success, employed it in 40 cases, and all recovered. Then Lomer had 16 cases with no deaths—93 cases, 1 death, 1 per cent. Eight other assistants had 85 cases, 7 deaths. Total, 178 cases, 8 deaths—4.5 per cent. mortality.² No other method has yielded such results in so large a number of cases. The only objection to be urged against the method is the theoretical one that turning increases the fetal mortality, but the results disprove this, for the fetal mortality was 60 per cent.,³ which is not above the average. The 178 cases were all treated by bi-manual version. If 58 additional cases, in which various other measures had been used before version was employed are included, the mortality was 21—under 10 per cent. This is an additional argument for Hicks' method. In these cases the Hicks' method was used *in toto*, and chloroform was freely administered.

Murphy's Method.—Murphy operates by no exclusive plan, but makes judicious use of several. He is a strong advocate of the induction of premature labor in all cases of placenta previa after the seventh month and "before that period when the hemorrhage is severe, continuous or frequently recurring." His method may be briefly described as follows: 1. Separate the placenta after the manner of Barnes. 2. Dilate the os with Barnes' dilators. 3. If hemorrhage continues, separate the placenta further. 4. When full dilatation is secured, give ergot freely. 5. "If the placenta is marginal or lateral, and the pains fairly strong, I rupture the membranes and leave the course to nature; or, if the head is well into the pelvis, I may apply the forceps; but in the great majority of cases I perform version, preferably by the combined method, and deliver the child as quickly as is consistent with the safety of the mother." The forceps were applied twice. Murphy had 23 cases, lost no mothers, and 13 children—56 per cent.⁴

Finally, we believe that the study of the lit-

erature of placenta previa justifies the following conclusions:

(a) *What should not be done in treating placenta previa:*

1. *Accouchement force* should be absolutely condemned. Lacerations of the maternal soft parts are almost inevitable; perhaps, also, death from shock or *post-partum* hemorrhage. The infant's prospects are not improved.

2. The membranes should not be ruptured before dilatation of the os, except as a step in combined version. Perhaps the greater mortality of Barnes over that of Murphy is due to this difference in practice. The manœuvre frequently fails to arrest hemorrhage; and renders subsequent version more difficult.

3. The tampon should not be used as an exclusive method of treatment. "It is a dangerous thing" (Lomer). It should be used only to gain time for more efficient measures.

4. Ergot should not be administered before full dilatation of the os is secured. It is then of value to hasten delivery and prevent *post-partum* hemorrhage. (Murphy, Wilson.)

5. Complete detachment of the placenta should not be practiced. It is very fatal for the child, and improves but little the prospects of the mother.

6. The fetus should never be turned by internal podalic version, unless the method of combined version has failed. The danger of introducing the hand within the uterus (laceration, sepsis) is thus avoided. Moreover, much time is saved.

7. The forceps should not be used, unless the head is well in the cavity of the pelvis, and hemorrhage or *inertia uteri* is present.

(b) *What should be done in treating placenta previa:*

1. In all cases premature labor should be induced after the seventh month, and before that period if the hemorrhage is severe, continuous or frequently recurring. This is done in the interest of both mother and child. The os should be dilated by Barnes' bags.

2. In cases of vertex presentation, when the placenta is marginal or lateral, after dilatation is secured by Barnes' bags (with or without partial separation of the placenta), the membranes may be ruptured, and the course left to nature. In some of these cases the forceps will be needed subsequently.

3. Almost all cases of complete and partial placenta previa are best treated by combined version, with slow and gentle extraction. Version may be done "as soon as one or two fingers can be inserted through the os" (the method of Braxton Hicks), or after

¹ *Obstet. Trans.*, Vol. V, p. 234.

² Lomer, *l. c.*, p. 1235.

³ Lomer, *l. c.*, p. 1247.

⁴ Murphy, *Medical Press and Circular*, 1885, Vol. II, p. 208.

the os has been dilated by Barnes' bags, and the placenta partially detached (the method of Murphy). Theoretically, Murphy's method allows of quicker extraction. By either, a maternal mortality of less than five per cent. may be expected.

4. Ergot should be used toward the end of labor to insure firm uterine contraction and retraction.

5. Strict asepsis should be maintained.

THE MANAGEMENT OF THE NEW-BORN CHILD.¹

BY J. J. CONNER, M.D.,
PANA, ILLINOIS.

The management of the new-born child is a subject which, though simple in name, I have found to be laden with very great responsibility. Physicians and parents alike are not apt to stop to consider the dictum of Jefferson's old professor of obstetrics, who was wont to say: "A child that is born does not surely belong to its parents until it has reached its sixth year; it seems to me that such a child is but a loan, on condition of becoming property, provided it be wisely and safely conducted up to the sixth year of its age, for one-half of the annual product of child-birth perishes in six years." In Chicago for the year 1887, forty-nine and one-third per cent. of the deaths occurred during the first five years of life. "It cannot be that this amazing mortality is an inevitable concomitant of the state of existence, but it must be largely a result of ignorance and carelessness as to the hygienic conduct of the neonatus and young child. It is true that a multitude of children are brought into the world with such feeble constitutions or such hereditary depravity as to render protracted existence and maturity impossible; but the population would find an immense augmentation were a sound discretion to preside over the hygienic management of newly-born children." The question may be very properly asked, when should this management begin? I answer, it should begin just as soon as the head emerges from the vulva.

The head of the child should be supported so that the face may be raised up from the bed high enough to prevent the child, in its first gasp for breath, from drawing up mucus, blood, water or faeces into its mouth, and thence into the air passages. If such an accident should occur, the child ought to be wrapped in a flannel blanket and laid on its

back upon a table, with its head hanging low down over the edge of the table, and a coarse-grained towel or a piece of mosquito-netting spread over the mouth and face of the child. While one hand is held tightly over the child's epigastrium, the physician should blow steadily and moderately hard through the meshes of the cloth into the child's mouth. Some of the air blown into the child's mouth enters the stomach in spite of the hand resting upon it, some enters the lungs and a part returns back through the nostrils, bringing with it portions of mucus or other foreign matter, which may be dislodged by the idle hand. I am in the habit, especially if the child rallies, of administering a teaspoonful or two of water, either warm or cold, as is most handy, to wash away any phlegm that may be in the mouth or pharynx of the child. It serves a double purpose, for it generally soon acts as a laxative to the young child.

If the child be born asphyxiated, I try to excite respiration as soon as possible by first placing my hand under the back of the child and gently raising the thorax, and shaking it until I find that insufficient. Then I dash a little cold water upon the child's chest and into its face, continuing the raising, lowering and shaking, and also making alternate pressure and relaxation upon the thorax. If these measures fail, I sever the cord, plunge the child boldly into a warm bath, and continue still to imitate respiration by the Sylvester method. One should not be easily discouraged if he fails to readily excite respiration in the new-born child. One person should be detailed for this purpose and instructed to persevere for several hours in his efforts to procure respiration. I suppose it has been the lot of nearly every one engaged extensively in the practice of obstetrics to see new-born children come to life, breathe, feebly though it may be at first, gradually gain strength, and live, when they had been at first given up to death. It has been said that a new-born child has been resuscitated as late as twelve hours after birth. Holding the child up by the feet and shaking it with its head down, has, it is said, resuscitated it after everything else had failed.

In ligating the umbilical cord I prefer a piece of stout tape, about one-quarter or one-third of an inch broad, to any other material. I use two ligatures; one is put on three or four inches from the navel, and the other about five or six inches from the navel. The cord is then cut with scissors between the two knots. I strip the cord completely of all the gelatin of Wharton before I tie either knot. If the cord is well stripped before it

¹ Read at the Annual Meeting of the District Medical Society of Central Illinois, April 24, 1888.

is tied, it dries up much better and is very much less liable to lead to inflammation of the navel.

The cord and navel are dressed with simple absorbent cotton alone. No grease of any kind is allowed to be put on them. If grease be put upon the navel it will be apt to turn rancid and produce irritation, and possibly lead to inflammation, erysipelas, and umbilical hemorrhage. It is thought by some that an inflamed navel often produces trismus nascentium by reflex irritation and systemic blood-poisoning through absorption of pus, etc., from the neighborhood of the umbilicus. Before putting the child's clothing on, it is thoroughly greased from the head to the feet, preferably with common lard. Special attention is given to the armpits, groins and other creases of the skin. Nothing will clean a child so readily of the vernix caseosa as good fresh lard. I do not allow any soap to be used upon the tender skin of the new-born babe. The face, hands and buttocks, if soiled by faeces, are gently and very lightly washed with a little soft water, into which the yolk of an egg has been thoroughly beaten up.

As the new-born child has the power of generating body-heat but very feebly, it should be dressed in material that will not conduct animal heat away from the body. That material of course should be woolen. I like the very softest and downiest flannel. There should not be a particle of starched goods in the make-up of the child's toilet. The clothes should be made up loose and baggy, somewhat after the style of the "Mother Hubbard" dress. It is not necessary to put on a belly-band if the child's petticoat has a waist-band attached to it. If there is no waist-band I put on a belly-band. It prevents the dressing of the cord from slipping around and getting misplaced or entangled in the clutches of an awkward nurse, and hence is not so apt to be suddenly jerked off of the child's belly or otherwise injured. I think it prevents hernia too, especially in children prematurely born or otherwise undeveloped. A good flannel bandage will go a great ways in preventing colic in the new-born by keeping the belly warm. The best material of which to make a belly-band is an old piece of woolen shawl, cut bias, so as to give elasticity and allow the belly to enlarge as the bowels evolve the intestinal gases through the process of digestion.

For the constipation so often met with in practice with babies, I have come to rely almost exclusively upon the compound licorice powder of the Pharmacopoeia. A suppository of soap generally answers every

purpose, and soap is found in every household. An elegant mixture is composed of equal parts of castor-oil and glycerine, to which a drop or two of oil of peppermint has been added. By correcting the mother's habit of costiveness it will generally suffice also for curing the habit in the child if it nurses, as all babies ought to nurse their own mothers.

I believe a child should have a full bath every morning of its life the first year of its existence. It should be entirely undressed and made to sit, or laid down, in a bath-tub. Its entire body should be thoroughly washed and rubbed with the palm of the hand. It should then be suckled and again put to bed, where, if it be a healthy child, it will sleep several hours.

I have no doubt that all practitioners will admit that the most difficult thing in the management of the new-born child is the proper feeding of it. It requires very great judgment on the part of the physician to at all times select the proper kind and amount of food which a child requires. It requires great tact and perseverance on his part to see that the mother and nurse faithfully carry out his instructions. A great many mothers are wofully careless and negligent in this important matter; others are ignorant to an alarming degree, and fail to comprehend the most plain and common-place instructions. Some are lazy and almost criminally wilful, and determined not to carry out the instructions left for them. It is needless to say that without a perfect coöperation of physician and nurse, or mother, that but very little indeed can be accomplished; but with a combination of interest by mother, nurse and physician wonders are accomplished.

If the baby has to be fed or raised by hand, the first thing to secure is a proper feeding-bottle. The shape of the bottle itself is to be looked after. A bottle with angles to it, like a common prescription vial, is to be avoided, for it is hard to clean, and a nurse who is slovenly, careless, or in a hurry to stop a crying baby's mouth, will often give a child milk which is contaminated with decomposing materials which are found sticking to the angles of the bottle at its bottom and neck. There is a feeding-flask now upon the market known as the "Graduated Nursing Bottle," and was made at the suggestion of Prof. Louis Starr, of Philadelphia. It is made of transparent flint glass, thus showing plainly the slightest foulness at a glance. The interior surface is made entirely free from angles, and an accurately graduated scale of fluid ounces, and half ounces or tablespoonfuls, is blown in

the glass. This bottle will be found very convenient and easily cleaned, and accurate in measurement, thus combining the essentials of a feeding-bottle.

The nipple for the bottle should be of the best black rubber, so that it will not irritate and make sore the child's mouth. I prefer the milk from a cow which has recently calved to that from a cow whose calf is some months old, or to that from what is commonly called a "stripper." The freshly calved cow's milk is richer in oil globules and more easily digested by the young child than the milk from cow which has been milked for a long time since calving. The milk from a stripper has more casein in it than that of the newly calved cow, and is consequently apter to curdle into large cheesy masses and give rise to colic, indigestion and diarrhoea. The formula which I have found to correspond best with the mother's milk, is about the following, viz.: Take one part of rich, new cream from the top of the milk-pan and add another pint of fresh milk and two pints of pure water unboiled; sweeten with milk-sugar preferably, but pure granulated sugar answers fairly well and is found now in every house; the whole should be slightly salted and warmed to about 100° F. A child during the first month of its life, should be fed about once in two or three hours during the day, and once in four or five hours during the night. Be careful about over-feeding the baby. Few children die of starvation in this land of plenty. They are nearly all over-fed with cow's milk, which brings about impairment of the gastro-intestinal functions. I have seen children literally starve to death after they had been over-fed to such an extent that they were unable to digest, assimilate and absorb nutriment which they were given. In just such cases as the ones now mentioned, we may be able to rescue a starving babe by the judicious application of cod-liver oil and mere common lard to the body of the child. One half ounce of cod-liver oil well-rubbed into the skin once every four hours, will often save the child, when otherwise it will surely die. The skin of a young child is very porous and will absorb nutriment rapidly. The stomach and bowels should be let alone for awhile during the rubbing in of the oils. I admit that it requires great perseverance and almost blind faith to succeed, yet success will sometimes be achieved where the usual method fails. Those of my colleagues who have never tried this method of feeding may have grave doubts of its efficiency, but I will only call to their mind the readiness with which a great many medicaments are taken up by the skin

and appropriated, and I ask why not nutriment as well? Before entirely condemning the method, I bespeak for it a fair trial at your hands. Of course medicines of various kinds may be very appropriately combined with the food substances and administered together. The secret of success of this method I believe to lie in the property of osmosis of the skin, and the small amount of nourishment required to sustain and strengthen a famishing child. After the alimentary canal has had a rest, the digestive organs will then resume their proper functions. All we have to do is to keep the child alive for awhile, thereby bridging over the stream, and we shall have gained our reward. Shall we give small children alcohol? I very emphatically say yes. Why? Because I verily believe it to be a food as well as a powerful, and at times the best, stimulant known to medical science, when used in certain imperative conditions.

PTERYGIUM COMPLETELY COVERING THE CORNEA.

BY JULIAN J. CHISOLM, M. D.,
PROFESSOR OF EYE AND EAR DISEASES IN THE UNIVERSITY
OF MARYLAND, AND SURGEON-IN-CHIEF OF THE
PRESBYTERIAN EYE AND EAR CHARITY
HOSPITAL OF BALTIMORE.

So seldom is a pterygium seen to exceed in its growth the border of the pupil, that some ophthalmic surgeons of large experience have never seen one of more extensive growth, and have consequently written that a pterygium can never shut out sight by covering the cornea, unless one starts from each canthus, and after many years of growth they meet half way over the pupillary area. The fallacy of this opinion I have an opportunity of showing every now and then, and more particularly in the last week. In accordance with professional experiences, three of these unusual cases presented themselves for treatment during one week at the Presbyterian Eye and Ear Charity Hospital of Baltimore.

Case I.—J. M., a man, 72 years old, had a pterygium on each eye, growing from the inner canthus. He had been more or less annoyed with them for twenty-five years. In the left eye the growth, quite a thick one, was encroaching upon the pupillary area and had commenced to interfere seriously with his vision. In the right eye the pterygium in its continuous development had not only completely covered the pupil, but was nearly touching the external corneal margin, so that nearly the whole cornea was covered over by the flesh-like layer. The external

canthus was perfectly free of all conjunctival complications.

Case II.—M. S., a woman, 68 years old, had the growth only on the right eye, and said that it was of two years' duration. She was not intelligent, and I could not get from her whether it had made her blind for that length of time or not. Evidently the starting point of the pterygium from the inner canthus was of much longer duration. In her case the web was a broad one, completely concealing the pupil, and extending half way from the external border of the pupil to the external border of the cornea. There was no growth from the external canthus, and the left eye was entirely free.

Case III.—J. S., a man, 63 years old. In this case the right eye alone was involved. The pterygium was of twenty years' growth. Starting from the common site, the inner canthus, it had slowly encroached upon the pupillary area, and had finally shut it in, in its continuous progress toward the external surface of the eye. The pupil could be seen only by looking very obliquely through the small rim of clear cornea on the side of the external canthus.

It was the presentation of these three cases for treatment on nearly consecutive days that attracted especial notice, and induced me to report them.

SOCIETY REPORTS.

AMERICAN MEDICAL ASSOCIATION: SECTION WORK.

First Day, May 8, 1888.

SECTION ON OBSTETRICS AND DISEASES OF WOMEN.

The meeting was opened by the President, DR. ELY DE WARKER, of Syracuse, N. Y., who welcomed the members to the present session, and delivered his address on the subject

How Gynecology is Taught, in which he discussed the various methods of instruction, and concluded by paying a glowing tribute to American gynecology, and especially to its founder, Marion Sims.

DR. PRICE, of Philadelphia, next followed with a paper on

Free Nursing as Organized in Philadelphia.

He described the system which had been there adopted of furnishing the poor and indigent with skilled nurses, by which operators were enabled to perform even most difficult operations in the homes of the poor, with proper assistance.

This institution was organized two years ago by two charitable ladies of Philadelphia. It is supported by voluntary contributions and such small amounts as the patients are able to contribute. The corps consists of seven well-trained nurses and their assistants. Two maternity nurses attend to the obstetrical part of the work, and separate nurses are employed for the care and attendance of contagious diseases. When an operation is contemplated at the home of the poor the proper nurse at once makes all necessary preparations and everything is brought in readiness for the operation. By this means the worst hovels in the very slums of society are quickly cleaned and made comfortable, so that even abdominal sections can be performed with safety.

This excellent plan is shown by the astonishing result of only *one* death in over ninety abdominal sections. The immense work done is further shown that out of 361 general gynecological cases, 90 were of a surgical character. In this year alone over two hundred cases were attended.

DR. W. W. JAGGARD, of Chicago, next followed with the reading of an essay, entitled

The Relation of Endometritis Gravidarum to the Persistent Vomiting of Pregnancy, in which he included the report of a case of hyperemesis gravidarum caused by endometritis.

In the case reported abortion was induced by introducing a bougie between the uterine walls and membranes after all other means for arresting vomiting had proven futile. Eight hours later the ovum came away and the placenta was removed according to Credé's method. The fetus was of eight months' gestation. The abortion was immediately followed by cessation of the vomiting. That the vomiting was not due to an artificial displacement of the uterus was proven by the fact that it occurred as late as the sixteenth to the eighteenth week.

DR. ADAMS ALLEN, of Chicago, said he accepted the case reported as a type of cases not infrequently met with it. He arose more particularly, however, to emphasize the method of treating uncontrollable vomiting generally. Most authorities recommend temporizing and delaying an interruption of pregnancy. The speaker thought such delay proved, too frequently, disastrous. The case reported showed the necessity of departing from such a rule, because a higher value should be placed upon the life of the mother than the child. The speaker now did not hesitate to induce abortion at an earlier

period than formerly, believing that thereby he could save life which otherwise might be destroyed. He therefore thought the essayist was perfectly justified in his treatment.

DR. W. H. WATHEN, of Louisville, was particularly interested in the subject of pernicious vomiting in general. He had seen but one case of truly uncontrollable vomiting, in the practice of another physician. The patient was two or three months' pregnant, and could retain absolutely nothing on her stomach, not even a tablespoonful of cold water. She was thoroughly emaciated.

The speaker at once dilated the cervix to the depth of one inch and a half by means of a steel dilator, not for the purpose of inducing abortion, but as a means of arresting the vomiting. Dilatation had previously been practiced by the attendant with sponge tents without affording any relief. After the dilatation, as above described, the nausea and vomiting abated, but abortion occurred a few days later. Unfortunately, the patient died of septicæmia sometime later because the attending physician could not remove the placenta entire and left portions of it attached to the uterus. Had the speaker attended the case throughout, he would have removed the placenta by the curette, if necessary. Although dilatation in this case was followed by abortion, it is not always so followed, and in these cases it relieves vomiting as well.

DR. NELSON, of Chicago, gave his experience in cases in which vomiting is due to flexion, either of the uterus primarily, or due to the displacement of the ovaries or disease of the adnexa.

In one case, a complicating fibroid tumor was the cause of the flexion, and hence also of the vomiting. He would relate a peculiar experience in connection with this matter. He once attempted to introduce a No. 12 English catheter for the purpose of inducing abortion. He allowed it to remain in situ a few minutes and then withdrew it with the stilet. After withdrawal he noticed a white, milky fluid, about twenty minims in amount, exuding from the end of the catheter. He was greatly puzzled to account for it. Had he opened an abscess cavity, or was it some physiological secretion—perhaps the so-called placenta milk? In his consternation, he neglected to save the fluid for examination, and it was therefore lost. It was possible that he had not exerted sufficient force to rupture a blood-vessel, but that the end of the catheter nevertheless passed into one of the uterine sinuses. The patient made an excellent recovery. The speaker believed that the fluid extracted was normal to this

body. He requested his hearers to make similar observations if possible and report them to him if they have similar experience.

DR. MAURY, of Tennessee, thought we should always endeavor, if possible, to preserve the fetus, but if the question of the safety of the mother's life arises we should not hesitate to induce abortion. He thus induced abortion three times according to the method reported by Dr. Jaggard.

DR. POLLARD, of New York, suggested the following modification: Instead of introducing a flexible bougie, a harmless and serviceable method is to take a large-sized piece of catgut, double it on itself, thus introduce it into the womb and leave it there. The catgut should first, however, be rendered aseptic. He resorted to this method in an extreme case with perfect satisfaction and good result.

DR. MORSE was of the opinion that in the great majority of cases, abortion results spontaneously, hence the induction of abortion will not be necessary.

The speaker reported two cases. In one the vomiting had lasted three months. After stomach feeding had become impossible, rectal alimentation was resorted to with some success for two or three weeks. Finally, however, it became necessary to induce abortion, which, unfortunately, resulted fatally.

The patient had had a chronic endometritis before marriage. An examination after marriage showed that the disease still continued, but on account of the absence of any great inconvenience the patient declined further treatment.

She then became pregnant and the result was the setting in of excessive vomiting. Abortion was produced by means of the introduction of a sound and tamponing of the upper part of the vagina. The ovum came away in about five hours. As the placenta did not come away entire the uterus was curetted thoroughly. The nausea and vomiting were indeed arrested, but the patient died of heart-clot the next day. The speaker thought that too long a time had been allowed to elapse between the discharge of the ovum and the removal of the placenta. If the uterus had been curetted immediately she would probably not have died. Another similar case reported terminated in recovery.

DR. MARCY inquired into the relationship of the placental and uterine villi to each other in the case reported by Dr. Jaggard. The speaker was of the opinion that there was a lack of proper relationship of the villi of absorption to those of secretion. At first the development of these sinuses is glandular,

but afterwards another process takes place, and this change is the real cause of the resulting endometritis. It is not really an endometritis—an inflammatory process—but a lack of proper development. He believed Ercolain was correct in his teachings regarding the structure and functions of the utricular glands. In the majority of cases the speaker thought dilatation for the purpose of arresting vomiting was useless, because it produced either death of the fetus or resulted in abortion in consequence.

DR. JAGGARD, in concluding the discussion, entered a word of protest against dilatation of the cervix simply as a means of arresting vomiting. In the largest number of cases it terminates in the premature expulsion of the ovum. He also preferred the introduction of a solid flexible bougie to a catheter with mandrin, on account of the danger of introducing air or septic material into the cavity of the womb.

DR. GOODELL, of Philadelphia, next read an entertaining, and in part humorous, paper on the

Nervous Rectum.

He described the rectum as being sometimes insane, as it were, whilst the rest of the body enjoys perfect sanity. One variety of this neurosis is the hysterical rectum, the muscles being thus affected, but the sphincters more so than the other set of muscles. A frequent form is spasm of sphincter, which renders defecation painful, and hence induces costiveness. These victims become easily addicted to opium eating. When the rectum is loaded a pulsating pain is felt. If there be in addition some ovarian irritation and enlargement the affection becomes very distressing.

Another form the speaker alluded to as the "jealous" rectum. He gave some very ludicrous instances where the rectum put its veto on any attempts at indulging in social intercourse. One lady always began to have an evacuation from the bowels as soon as she received a letter from her husband, and was obliged to delay reading it until the rectal demands had been satisfied. A second individual would soil her bed after any violent mental emotion. All these persons were kept prisoners at home and had to abandon social intercourse.

A third form he described as "follicular colitis" or "membranous enteritis." He found this affection so often in hysterical patients that he looked upon it as a neurosis, just as pruritus, shingles, etc., are nervous skin affections. He found all these forms of rectal trouble as being peculiar to emo-

tional women of high intelligence: none of them belonged to the lower walks of life. The diagnosis between these neurotic troubles of the rectum and disease of the coccyx is readily made by the introduction of the index finger into the rectum and the thumb over the coccyx, showing that this appendage is movable.

The treatment depends on the form of the trouble. He regarded that of Weir Mitchell for nervous prostration as the best. Seclusion, forced feeding, massage and electricity, the latter two equalizing the nervous fluid and stimulating a healthy action of the nerves. As soon as enemata can be borne, they should be administered before bedtime. Suppositories of iodoform act beneficially, and, in case of spasm of the sphincter, stretching of the sphincter ani. Follicular colitis is almost incurable, but may be soothed by means of suppositories of iodoform, antipyrin, etc. Sometimes injections of lime water or Carron oil greatly relieve this trouble. He cautioned strictly against the use of opium in any form, as these patients are very apt to become opium eaters. Altogether the best medication consists in the administration of remedies constitutional in their action. His favorite prescription is the pil. sumbul comp.; Blaud's pill is an excellent remedy, beginning with one pill three times a day, gradually increased until three are taken after each meal. Occasionally he gave as many as five after each meal. Pills composed of the three valerianates (zinc, iron and quinine) are of great value, also pills composed of chloride of gold and soda. When malaria is at the bottom of the trouble, Fowler's solution acts well. The bromides are often needed and may be advantageously combined with the bitter tonics, as the tincture of gentian comp. When the paroxysms are sudden, antipyrine and the hydrobromate of hyoscine are serviceable. Absolute rest of mind and body secured by absolute seclusion in a darkened room is sometimes indispensable.

Specimens and Instruments.

The Secretary, DR. E. W. CUSHING, presented for Dr. Reamy two specimens of tubercular salpingitis, the tubes and ovaries having just been removed by Dr. Reamy.

DR. HOWARD A. KELLY, of Philadelphia, next exhibited a number of gynecological appliances for the use of the specialists in this department. A number of rubber sheets of various shapes to adapt this for the different operations, ovariotomy, perineorrhaphy, etc., were shown, their object being to drain off the fluids thoroughly and yet insure cleanliness. An ingenious rubber bed pan was

also shown. A pair of simple leg holders (*Beinhalter*), inexpensive and easily made, were passed around. Among instruments devised by the same gentleman were a speculum for the knee-chest position, a series of glass (antiseptic) catheters, drainage-tubes with flanges, new sponge forceps, knife-blade tenaculum, a modification of the Bozeman-Fritsch catheter, etc.

Cases of Hysterectomy.

DR. GORDON then gave a brief account of three cases of vaginal hysterectomies, lately performed. He made an earnest plea for an early operation, as it is now assumed that cancer is first local and afterward constitutional. It should be a golden rule, that where a disease has naturally a fatal tendency if left to itself, an operation is justifiable even if it should terminate in death. The immediate mortality in hysterectomy is not very great; Martin reported only eleven deaths after sixty-six operations.

His first patient was 38 years of age; the evidence of cancer was only of six weeks' duration, according to symptoms, consisting of a growth on the posterior lip of the cervix. Vaginal hysterectomy was performed, with complete recovery. In another patient, 56 years of age, who had an offensive discharge and hemorrhages, the operation was followed by immediate recovery. In a third case, where the cancer was of a year and a half's duration, the patient died from supposed inflammatory intestinal obstruction.

DR. MARCY reported three cases in which Martin had operated in Boston. One of these subsequently died from hemorrhage, the autopsy revealing that one artery had escaped ligature. He could hardly account for this when noticing Martin's thorough method of securing the blood-vessels. Another case died from heart trouble. An autopsy was refused.

DR. GOODELL was still on the fence. He operated twice in this manner; his first patient died of septicæmia on the third day. The second recovered from the operation, but died from hemorrhage in less than six months. In the future he would leave the clamp forceps on the vessels instead of ligating them. In liberating the uterus from its attachments, he first made the posterior incision and hooked down the organ by means of the old obstetric crochet. He thought that in the future, however, he would make no attempt to retrovert the womb, but simply draw it down with the forceps attached to permit drainage.

DR. CUSHING, of Boston, described Martin's method: He hooks down the uterus with

a powerful forceps. Alluding to the paper of Dr. Reeves Jackson, at the last International Medical Congress, the speaker said he laid great stress upon the statistics on the period of time a woman lived when not operated on. The speaker would reply as did Dirner, of Buda-Pesth, that five years longer life of misery in one woman does not count against another whose life is greatly improved by operation.

DR. GOODELL said he had had excellent results from the high vaginal amputation—one patient lived fifteen years after this operation had been done, and the stump treated with a mixture of 15 grains of the bichloride to an ounce of collodion.

DR. GORDON said in reply, that if the whole uterus is out, this is better than having only part of it out. He retroverted the uterus by means of a stiff sound.

SECTION ON DISEASES OF CHILDREN.

DR. CHARLES WARRINGTON EARLE, of Chicago, read a paper on

Infant Feeding:

- (1) Foods for Prematurely Born Children;
- (2) Mixed Diet; (3) Artificial Foods; (4) Feeding in Acute Disease.

Dr. Earle began by saying it was particularly appropriate to present to the section a brief *résumé* of what Baginsky, the latest German author on diseases of children, writes on the subject.

The greatest mortality in all climes and among all nations is due to the lack of mother's milk. In Berlin, one-half of all children born out of wedlock die within six months, and during the summer months a large proportion of children succumb to errors of diet.

Fermentation of milk occurs only in consequence of the introduction into it of micro-organisms. If the milk be received by a sterilized tube into a sterilized receptacle directly from the udder of the cow, it will not ferment, nor become acid, though kept indefinitely. But except these precautions are taken, the germs always gain access to it; consequently in order to prevent its fermentation, it is necessary to heat it. It can be sterilized by heating to 70 degrees for an hour, by which process the adult bacilli are killed; although it is necessary to repeat the process for an hour each day for four or five days in order to kill the spores. Heating to 100 degrees by a current of steam for one hour will sterilize it completely, but boiling coagulates the

albumen and to some extent changes the milk sugar.

The first process in the fermentation of milk is due to the action of a bacillus, and consists in the conversion of the milk sugar into lactic acid. This process ceases after a small quantity of acid is formed, but if the acid be neutralized by chalk the fermentation will go on until the milk sugar is all decomposed. By the change of re-action of the milk the casein is coagulated. This coagulation is said to be due to the action of the acid and not directly to that of the bacillus. When the milk sugar is converted into lactic acid, another bacillus—bacillus subtilis—attacks the lactic acid and converts it into butyric acid with evolution of carbon dioxide and free hydrogen. This bacillus cannot act on milk sugar unless it is first converted into lactic acid.

Under exceptional circumstances there is formed in milk a substance first discovered by Prof. Vaughan of Ann Harbor, and named by him "tyrotoxicon" (cheese poison). This substance is a crystalline nitrogenous substance, and is supposed to be a ptomaine. When taken, it produces pain at the base of the brain, vomiting or retching, and purging. When given to an animal, similar symptoms are produced. Prof. Vaughan believes this to be the cause of cholera infantum. Tyrotoxicon is formed spontaneously in milk after some months; but it will be produced very quickly if some milk in which it has been formed be added to fresh milk. Its formation seems to be connected with the butyric acid fermentation.

In conclusion, Dr. Earle asserted that nature does not afford, nor can art supply, a substitute for mother's milk. Mothers should be encouraged by every argument possible to nurse their children, and the dangers of too early weaning should be demonstrated to them. If from causes which we cannot control, and which seem rational and valid, a mother cannot nurse her child, then in cities at least, a wet nurse should be procured. A mixed diet is preferable to an artificial one. For very young infants, in lieu of mother's or nurse's milk, cream with barley, rice or oatmeal water, to which milk, sugar and either common salt, phosphate of lime, or lime water, in small quantities, is added, seem to agree best. For older children, cow's milk and the so-called milk foods, are best. It would seem from some recent analyses of cow's milk that if all kinds of fermentation can be prevented, without the task of preparing cow's milk, so that it will agree with infants, feeding will not be as difficult as it

has formerly been. It also seems that it is along this line that investigation in the future should be made. We must not only insist that good milk shall be provided, but also that it shall not have in it bacteria. If milk is used, let it be thoroughly boiled, and for a long time. If it is diluted with water, let the water be absolutely pure. If the attempt is made to make it more nutritious by the addition of cream, let it be that which has not already undergone partial decomposition. The sugar added should be pure milk sugar, and if a small amount of wheat and flour should be used, this too should be thoroughly cooked. If artificial foods are used, let the clinical test decide which shall be selected, and when food is found to agree with a child, let the growth and increased nutrition of that child, or its loss in weight and commencing atrophy, be the guide for the substitution of some other food. I cannot designate particular foods for reasons perfectly obvious. Every food has its advocates. Every food has its chemical analyses, which prove without a shadow of doubt that it is chemically and physiologically the only substitute for mother's milk, and yet every one of them sometimes fail us. I will admit that this is true of mother's milk in rare cases, but as a rule let our advice be in the order I now name: Mother's milk, nurse's milk, mixed diet, cream foods, milk foods, malted foods, farinaceous foods, always pure, free from bacteria, and each preparation, whatever it be, frequently inspected.

SECTION ON DERMATOLOGY AND SYPHILITIC GRAPHY.

The session was opened by an elaborate and exceedingly interesting paper by the Chairman, DR. BULKLEY, on

Syphilis as a Non-venereal Disease.

The discussion on the

"Etiology and Treatment of Eczema"

was opened by DR. BULKLEY, who said:

The question presented for our discussion this afternoon is one of such magnitude that it is manifest that not more than the outlines for consideration can be sketched at present. In the etiology of the disease we have to distinguish between the predisposing and the exciting causes of eczema, between the constitutional state or condition, and the special determining causes of the attack, internal and local. We know as yet nothing of the real internal causation of eczema, except as we can observe clinical facts of the association of certain symptoms or conditions of system in connection with, and apparently

causative of the disease. I believe the first element to be recognized is *debility* in some form or other. Eczema never occurs except as an evidence of lowered vitality, either general or local. The local element will be considered later in connection with the local exciting causes of the eruption.

The evidences of debility in patients with eczema take three general forms: First, those which relate to digestive and excretive functions; second, those which affect the nervous system and present neurotic symptoms; and, third, those connected with nutrition, or the life process of the body, known as the scrofulous or strumous state.

The first of these is by far the most common, forming fully one-half of all cases, and represents what is known as gouty eczema; the second, or nervous causes, may exist alone in a certain proportion of cases, but often enters as an element in patients belonging to the first class; the third, or strumous condition, is less common than the others, and rarely determines the disease alone, without the intervention of the two preceding causes.

This lowered vitality may come from many causes. In some instances simple over-work or worry, producing nervous exhaustion, may induce and keep up the disease. In more cases assimilative debility, manifested by disorders of the digestion and excretions, plays the most important part, while in other instances a strumous condition of the system seems to be the main factor, and in a few instances heredity is an important element.

Digestive derangements are undoubtedly the most important elements to be considered etiologically in eczema, and again and again their effect may be observed by careful study in many cases. Acidity will always aggravate an eruption of eczema of any extent, and constipation will often be followed by fresh outbursts of the same.

DR. ZEISLER, of Chicago, said: there are two theories concerning eczema: The first, advanced by Hebra, that eczema came from local causes. His strong argument in favor of this theory was that he could produce a local eczema in any individual, in any place, and at any time. His successful treatment lent weight to this theory. The second theory, held extensively in England and America, represents eczema as a constitutional disease, due to ill nutrition. The truth probably lies between these two theories. Many cases are no doubt due to local causes, *e. g.*, eczemas of washerwomen, shoemakers, surgeons, exposure to sunlight, etc. These may, however, be explained by individual peculiarities. Many cases are undoubtedly due to

internal causes, but to ascribe all cases to constitutional causes is to transcend our knowledge. Eczema in children is sometimes due to nervous causes, as in teething. Rheumatism is a cause of chronic eczema. Disturbances of digestion are too often blamed as the cause of eczema, for the number of cases of indigestion is out of proportion to the number of cases of eczema, except in infancy. Whether eczema be due to organisms or not, remains to be seen; if so, many subdivisions of what we now regard as one disease will have to be made. I believe in local treatment, but my views have, of late, been modified. I limit the use of arsenic to chronic, dry eczema.

DR. RAVOGLI said: in considering the etiology, it is necessary to look at the general condition of the individual. The same cause often works differently in different individuals. This is due to the general condition of the skin, whether it is soft or tough. Thus we find that age makes a difference. The symptoms in children are entirely different from those in adults. It is more acute in children, and in old age more chronic and inclined to the scaly form. He did not believe in a scrofulous eczema. Eczema is a catarrhal condition of the skin. Scrofulous subjects may, however, be more predisposed to eczema. Obstacles to the circulation, as scars, fractures, and varicose veins, are sometimes a cause of eczema. Had had excellent results with the use of salicylic acid and resorcin in eczema of children.

DR. REYNOLDS, of Chicago, said that the causes of eczema were both local and constitutional. He relied most upon the local treatment, never losing sight of the constitutional condition, which may aggravate or prolong the disease. For the local treatment, he divided eczema into acute, sub-acute and chronic cases. The treatment of the first was soothing, of the second, soothing, and mildly stimulating, and of the third stimulating. The other constitutional conditions, of course, require their proper treatment.

DR. RICKETS, of Cincinnati, said that he had seen a number of cases in the city during the late epidemic of typhoid fever, and had invariably found an excess of acid in the urine. What relation there was between this fact and eczema he did not know.

DR. FLEISHER, of New Haven, said that gouty eczema was a new form to him, and that eczema was due to blood-stasis, either venous or arterial. He believed struma a cause. He considered that Hebra's experiments in the production of eczema proved nothing, nor was it established that it was caused by special occupations. Such coinci-

dence might be due entirely to similarity of conditions. In the treatment he had found arsenic of great value, but he uses it less than formerly. He believed in the three-fold division of the disease. He had obtained good results from mild external treatment, especially from the use of the ointment of rose-water. In some cases he found great benefit from free purgation.

The next paper read was by WILLIAM T. CORLETT, M.D., Cleveland, on

A Clinical Study of So-Called Prairie Itch.

From time to time one meets with reports in the medical press of diseases of the skin, closely allied in symptoms to scabies, yet it is claimed differing therefrom in certain essential details. This is claimed to possess four cardinal diagnostic points: The first, pruritus, is always present but varies in intensity, being in some cases continuous, but in some cases there are periods of exacerbation, notably at the close of the day. The second symptom consists in a papillary eruption varying in distribution. The hands and forearms are most frequently affected, next in order the trunk and thighs, while the face does not always escape. The third symptom, or more properly, etiological feature, has been the *bête noire* of several amateur microscopists, who have ascribed its contagious or infectious nature to a hitherto unlabeled parasite. The fourth distinguishing feature arises from the observation that, although resembling scabies, yet it does not yield to therapeutical measures best suited to that disease. One or more of these features are present in every case of so-called prairie itch.

In 1854 Dr. William Brodie, of Detroit, took the position that prairie itch was unrelated to scabies, which position, if I mistake not, he still holds, despite the advance made in dermatology since then. In the winter of 1885, it was estimated that one person in every twenty in Louisville had the itch. This epidemic, Dr. Hyde, of Chicago, thought was probably due to an unusual series of cold waves from the Manitoba region. A writer in the Kansas City *Medical Index* for August, 1886, describes the group of symptoms herein considered, and concludes that it is not scabies, nor a disease peculiar to this country. Dr. Engstad, of Dakota, however, has made a careful microscopical investigation and has not found the acarus.

In November, 1885, the "new itch" was reported to be epidemic in Portage and Wayne counties, Ohio, and a committee was appointed from the Northwestern Medical Society to investigate the same. The committee reported: The disease for the most

part is scabies, due to the acarus scabiei. The treatment and hygienic measures suggested by the committee were successful in exterminating the epidemic.

(The doctor here gave a more or less detailed account of the history of ten cases which he had studied in hospital and private practice, and which belonged to the same category as those he was discussing.)

In May, 1887, I saw several cases of what is popularly known as the Michigan itch, or lumberman's itch, in the hospital of the University of Michigan.

Other cases in many Western towns of Pennsylvania, which claimed to be specimens of prairie itch, were found to range from scabies to phtheiriasis, from erythema simplex to eczema pustulosum, from pruritus to herpes, and from pityriasis to xeroderma. It is not that scabies has disappeared with increasing civilization, but that we lose sight of the clinical fact that the acarus scabiei is only a local irritant, inducing in one a papillary, in another a vesicular eruption, which in another again may become pustular. Frequent bathing will put a limit to this local invasion; thus it is seldom seen on the hands and faces of those who bathe frequently. Again, the senso-neuroses, which become apparent to American dermatologists, often baffle the most skillful. But, from the mass of cases examined, it is apparent that there exists no material for a new disease, but an appalling need of a more thorough knowledge of those we already have.

DR. ZEISLER, of Chicago, opened the discussion of Dr. Corlett's paper by saying that the cause of the so-called prairie itch was ignorance in regard to skin diseases. The doctor related several incidents showing the ignorance of many of the general practitioners with regard to dermatology.

DR. REYNOLDS said that his practice in the West had given him opportunities for seeing many cases of this so-called new disease. He had always found that this diagnosis was made by men who were not well posted in dermatology. All the cases of prairie itch he had ever seen were typical cases of eczema. He saw little of scabies, but many cases supposed to be scabies were, in reality, eczema. The peculiarity of the prairie itch is the appearance of contagion, which is thought to distinguish it from eczema. This imaginary contagion may be due to the fact that all of a family are under the same hygienic, dietetic, and local conditions. Itching seems to be almost contagious, and the scratching ensuing may occasion a disease of the skin.

*Second Day, May 9.*SECTION ON OBSTETRICS AND GYNECOLOGY.
ELY VAN DE WARKER, President.

E. W. CUSHING, Secretary.

The second day's proceedings opened with the election of Dr. W. H. Wathen as Chairman of this Section.

Dr. A. B. Carpenter, of Cleveland, was next nominated as Secretary, and, as no further nominations were made, was elected by acclamation.

The first paper read was by DR. L. H. DUNNING, of South Bend, Ind., on

Double Uterus and Vagina.

The paper was illustrated by a number of large drawings on the various malformations of the uterus and vagina, consisting in duplicities of these organs. After explaining the origin of these anomalies from errors in development in the generative organs from Müller's ducts during embryonic life, and presenting the various forms of double uterus and vagina, he gave complete statistics of the number of such cases reported up to the present time. When pregnancy occurs in a double uterus the unfavorable position of the impregnated uterus is apt to cause miscarriage or difficult labor. These abnormalities are usually confined to the uterus and vagina, the ovaries being rarely implicated. This is readily explained by the fact that these organs are developed from separate germinal bands. Of great interest are the anomalies of menstruation. In addition to the healthy action of the ovaries, there must be a communication between the tubes and uterus, and of the latter organ with the vaginal outlet, to establish normal menstruation. If, owing to malformations, there be any obstruction, there may result various anomalies. One-half of the uterus may become impregnated whilst menstruation occurs from the other half, or pregnancy may occur in both divisions, with different periods of impregnation. This departure from normal menstruation shows the important influence of the uterus over this function. The effect of a duplex vagina over pregnancy is but little described by text-books. Whilst impregnation may take place, labor may be delayed at either by the presence of this septum. It may become torn through the progress of labor, or must be artificially divided before the latter can be completed. The essayist said it may be incised, or removed by the galvano-cautery. Personally, he favored excision and suturing the edges. If an incision be made, it should be crucial.

The time of interference is of some importance; if the anomaly be discovered but shortly after pregnancy it is better to wait until the fourth or fifth month before operative measures are resorted to, as pregnancy is less likely to be interrupted at this time than in the earlier months. At all events it is better to cut the septum than to allow it to be torn away during labor.

Finally, the author came to the following conclusions:

1. Congenital malformation of the uterus or vagina are more frequent than is usually supposed.
2. Of the different anomalies, uterus bicornis is the most frequent form—over fifty per cent.
3. The fecundity of women thus affected is not materially diminished.
4. As a result, however, difficult labors are more numerous.
5. In all established cases of uterus bicornis pregnancy has thus far occurred.
6. The forms of malformation of the uterus in which abortion or miscarriage are most apt to occur are the uterus didelphys and uterus bilocularis.
7. Both divisions may be pregnant at the same time and in different stages.
8. Disorders of menstruation are very apt to occur.
9. The amount of the menstrual fluid when normal is small.
10. Menstruation may occur simultaneously from both uteri, or one may alternate with the other.
11. The disturbances caused by these anomalies shows the important part that the uterus plays during female life.

DR. W. H. TAYLOR, of Cincinnati, in opening the discussion, stated that in the past two years he had seen two cases of duplicity of the uterus and vagina. One was a case of complete separation of the vagina, the septum extending from the os *vaginae* up to the *os internum* of the uterus (*os bilocularis*). This woman became pregnant, and at term the child, in breech presentation, straddled the vagina and tore a portion of the septum away in its descent. The untoned portion had then to be divided. This case occurred in the Cincinnati Hospital. The other case did not become pregnant. Here the partition extended only from the external genitalia to the *os* (*vagina bipartitus*). This is a much rarer form of malformation. County says a double uterus without double vagina occurs one hundred times, whereas a double vagina without double uterus only fifteen times.

DR. GOODELL reported a case of double uterus in which he had made an erroneous diagnosis of extra-uterine pregnancy, and as such presented it before his class. He had passed the sound into one horn of the uterus to demonstrate, as he thought, the extra-uterine pregnancy, and he was only prevented from making a serious blunder by observing the contractions under his hands of the pregnant uterus, and the delivery followed a few days afterwards. The diagnosis in these cases frequently becomes difficult.

DR. KELLY, of Philadelphia, said he had seen six cases, of which one was recorded in the *Medical News*, a uterus septus with vagina septa. The introduction of the Goodell speculum plainly showed the menstrual fluid coming away in drops from each half. He had one case of vagina subsepta, the lower portion of the vagina being divided, whilst the upper was normal. This case presented some difficulty in coition. In another case he removed a parovarian cyst, since which time the patient conceived and passed an ordinary labor. He would call attention to one peculiarity as a means of facilitating diagnosis in bimanual examination, namely, the depression of the fundus in double uterus. Also the flattened shape of the fundus may be recognized in another form, as the famous case of undeveloped uterus of Rokitansky.

DR. FRANKLIN N. MARTIN, of Chicago, read a paper on

The Value of Galvanism as applied by Apostoli in the Treatment of Fibroid Tumors of the Uterus.

After briefly recounting the history of this method, with its growing success both in the new and old world, the author describes his improvements as made in the construction of the intra-uterine electrode, by means of which an exact dosage can be attained. The surface of the endometrium exposed to the galvanic current is accurately determined by the size of electrode employed, those used by the author measuring two and four square centimetres respectively. He also exhibited the large abdominal electrode, consisting of a hollow metal disc filled with water and covered by animal membrane, as an improvement over the cake of clay employed by Apostoli. After briefly reviewing the history of cases thus treated by him, the author stated that from January 1, 1887, to January 1, 1888, he had used galvanism over fourteen hundred times in the treatment of fibroid tumors, 653 times in fifteen cases. Of these five were completely cured and

five symptomatically benefitted. After describing the method of using the galvanic current for the treatment of tumors the author concluded his paper with the following summary:

1. A means of generating a continuous current of electricity of steady and uniform character, that can give an actual current strength through a resistance of two hundred ohms of five hundred milliampères, is necessary in order to obtain all the benefits of this treatment.
2. Fibroid tumors of small size can be completely absorbed by the proper application of strong currents of galvanism.
3. Hemorrhages from hemorrhagic fibroid tumors can be promptly cured by the local coagulating effect of the positive pole when it is applied intra-uterine. Severe neuralgias, so often accompanying these troubles, can invariably be relieved by three or four applications of this treatment.
4. When the cervical canal cannot be entered by any form of intra-uterine electrode, flexible or otherwise, after repeated trials, a negative galvano-puncture should be made into the presenting part of the obstructing mass of the tumor and an artificial canal opened, which is to take the place of the impenetrable uterine canal in all subsequent treatments.
5. The intra-uterine electrode should in all cases be negative, unless there is hemorrhage or excessive leucorrhœa, when the positive pole is always required. The same patient may, however, present symptoms demanding the use of both poles at successive operations.
6. The strength of the current should depend entirely upon the amount of active surface of the internal electrode, and should be twenty-five milliampères for each square centimeter of active surface in actual contact with the endometrium. If more is used the concentration of the current will be sufficient to cause troublesome cauterization; if less is used the concentration will not be sufficient to cause the necessary coagulation for checking hemorrhage.
7. The duration of the treatment should be five minutes of the maximum current required.
8. The number of operations is necessarily dependent on and influenced by the result to be accomplished. A severe hemorrhage can be checked and symptomatic relief can often be accomplished by four or five seances, while a general reduction of the tumor necessitates many operations, varied, of course, according to the size and location. In some

cases of large multiple tumors a relief of symptoms, or symptomatic cures, must be accepted as a substitute for an actual cure.

9. The operation should be intra-menstrual, if possible; if hemorrhage is continuous, however, operate during flow. The seances can occur as often as every day with the system of concentration adopted that enables one to attack different portions or the canal at succeeding treatments, or this can be given with advantage as few as once a week.

10. Since the adoption of the flexible intra-uterine electrodes and Dr. Apostoli's vaginal galvano-puncture, extra-uterine puncture should be regarded, if at all, only as a last resort.

11. Galvano-puncture needles and the internal electrodes should be constructed of material that is not injured by coming in contact with strong carbolic acid, or 1:1000 bichloride mercury solution. All internal electrodes should be thoroughly scrubbed with a nail-brush and soap and water after each application, and allowed to remain in one or the other of these standard antiseptic solutions until they are to be employed again, when they should be washed in a weaker solution of the same before using. Before a vaginal puncture is made the vagina should be thoroughly wiped out with a 1 to 3000 bichloride solution.

12. There is no excuse for any percentage of mortality in the proper application of this treatment. While Dr. Apostoli had two deaths in two hundred and seventy-five cases, he candidly admits they were due to avoidable accidents rather than to any legitimate procedure of the operation.

13. In experienced hands, and by the adoption of the present means of concentration, the most delicate and sensitive patient can receive, without experiencing any severe discomfort, all the benefits to be derived from this valuable treatment.

DR. A. B. CARPENTER, of Cleveland, O., next described a

New Method for Supplying the Electrolytic Current in Uterine Fibroids.

The author spoke of the difficulty of keeping the ordinary physicians' batteries in good running order, and therefore devised a method of supplying the electric current at any time desired in the proper strength. He took his current directly from the street, using the electric current as furnished by the Edison light for this purpose. The Brush light is too dangerous, but the Edison system, which furnished an electric intensity of 100-110 volts, will not prove dangerous even with the entire strength outside of the rheostat.

The author exhibited the working of his apparatus, with the wires attached from the street.

In opening the discussion, DR. NEWMAN said that the electric current has always an electrolytic action, the amount depending on the strength used. If the current be small, the current will act as an absorbent; if large, it may prove destructive. He formerly claimed that a strong current should never be used, but in the light of recent developments he took it all back in considering the treatment of fibroid tumors, the large electrode diffusing the strength of one pole over the whole abdomen, overcoming the destructive tendency of a current of too great an intensity. The result will depend upon the concentration of the current upon the electrode. It is true that operators differ as regards the *modus operandi* in their treatment of tumors by electricity. Freeman, for instance, achieved good results with pointed needles. The speaker would, however, warn beginners against using needles with fine points, even in intra-uterine puncture, because it might be followed by fatal results. He himself used an intra-uterine sound, insulated, except at the end, to the depth of the uterus. This he attached to the negative pole and gradually passed it into the womb. If the canal be tortuous, this passing in may, at first, be difficult, but gradually the sound will enter deeper. The opponents to the use of electricity for this purpose say that it does not always cure them. He would reply that the object is not to entirely remove them, but to diminish the size as much as possible, so that they become harmless. If more than this can be done, so much the better.

DR. MARCY, of Boston, said that for his knowledge of the use of galvanism, for its electrolytic action in tumors, he was first indebted to Dr. Cutter, of New York, whose pupil he was. At that time he saw cases benefited by this treatment, but also saw occasionally dangerous results. He then discarded its use, and was with great difficulty re-converted, until he heard of Apostoli's great success. He then again supplied himself with an electric apparatus, and since then had had unqualified success. If we could utilize the street lamps for this purpose, he regarded it as a great improvement, altogether a new departure. In conclusion, he greatly lauded the advances made by the two gentlemen in this direction, throwing additional lustre upon American gynecology.

DR. MARTIN, in reply to a question, stated that the only improvement in his

animal membrane electrode consisted in its greater cleanliness and handiness. His dynamo enabled him not only to obtain high tension, but also a cautery current.

DR. CARPENTER, in concluding the discussion, stated that he always began with a low dosage. He thought it better to employ a longer sitting and reduction of strength in the beginning. Antiseptic precautions should also be instituted. He laid special emphasis upon the importance of rest after each seance. It is his practice to keep his patients at least one hour in his office before permitting them to leave. The great relief afforded at each sitting will often induce women to visit their friends and thereby frequently set at naught all good effects obtained. In conclusion, he narrated an intractable case of vesical irritation, in Cincinnati, which was truly in a pitiful condition. After four treatments the incontinence of urine entirely disappeared and the patient became greatly relieved.

One of the most instructive, as well as entertaining features of this session was the exhibit of micro-photographs, illustrating microscopical

Studies of Endometritis, Adenoma and Carcinoma Uteri

By DR. E. W. CUSHING, of Boston.

The pictures were thrown upon a large canvas from the stereopticon, and were very beautiful. Each picture was graphically and lucidly explained by the exhibitor.

SPECIAL CORRESPONDENCE.

LETTER FROM CINCINNATI: MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

Wednesday, May 9, 1888.

The second day of the Association meeting has been especially distinguished by the report of the Trustees of the Journal, which contained figures indicating that the income of the Journal had increased last year, and that the outlook for its prosperity is very good. I am betraying no secret when I say that there is a deep dissatisfaction on the part of many of the members of the Association here with the way the Journal has been conducted; and there is a feeling that if its increased revenues have been secured by the abuses of its pages by advertisers during the past year, the Association cannot congratulate itself upon this fact.

I hear a great deal of complaint that the Journal is not what it was intended to be, namely, a substitute for the volume of transactions. Men complain that the proceedings of the Association are not properly reported in the Journal, and that the papers are not published in regular order or according to any well arranged plan. They say here that it is too much filled with the proceedings of the Chicago and Illinois societies, and that papers read at the meeting are pushed aside in order to make room for papers which have not been presented to the Association at all, and which were written long after the ones which they have displaced.

In connection with the complaints against the way the Journal has been conducted, much comment has been excited by the fact that the manufacturers of the Ivory Soap have circulated broad-cast at this meeting *fac simile* copies of a letter by Dr. N. S. Davis, endorsing and recommending this soap for use by physicians.

To return to the meeting: Dr. E. A. Wood presented on Wednesday a report from the special committee on dietetics. Dr. Wood has undertaken the work of interesting the Association in this important subject, and his labors were crowned with signal success. His report was listened to with deep attention, was received with the warmest expressions of approval, and its reading was followed by the adoption of a resolution making *Dietetics* one of the regular subjects for discussion at the annual meeting.

The social feature of to-day was a handsome reception by the members of the profession in Cincinnati to the members of the Association at the Art Museum, in Eden Park.

Thursday, May 10.

Among the proceedings of the general meeting to-day Dr. E. M. Moore, of Rochester, N. Y., read the annual address on surgery, which was a very interesting and scholarly document. The committee on the Rush monument reported progress, but announced that the responses to the recommendation of the Association that the members contribute liberally to the proposed monument had been far from satisfactory. The report of the Treasurer of the Association was read and approved.

The section meetings were interesting and well attended; and in the evening a delightful concert was given to the members of the Association and their friends in the Music Hall. This was very largely attended, and was one of the most successful entertainments of the meeting.

It was made known to-day that the Nominating Committee have selected Newport, R. I., as the place for the next meeting, Dr. Dawson, of Cincinnati, for the next President, and Dr. Pepper, of Philadelphia, to deliver the address on General Medicine. The latter choice is supposed to be intended to make up for the failure to accept an invitation to take the Association to Philadelphia next year. The choice of the place for the next meeting has been perhaps the most exciting question before the Association this year. The delegates from the Philadelphia County Society came here bearing a unanimous invitation from their Society to the Association to meet in Philadelphia in 1889. This invitation was understood to be tendered for the purpose of testifying to the good will of Philadelphia toward the Association, and of renewing the friendly relations which had been impaired by certain occurrences during the last few years. There can be no doubt that it would have been accepted, but for the fact that a few medical men from Philadelphia worked hard against it, claiming that the invitation was offered in order to get an opportunity to snub them and a college in which they are interested. It is believed that this fact, together with some arrangements in connection with the name of a candidate for the Presidency, prevented the acceptance of Philadelphia's invitation. Another thing which had some bearing upon the case is the fact that the delegate chosen to represent New Jersey, although instructed by his delegation to vote to go to Philadelphia, actually voted and spoke against this proposition! It is said that his conduct will be inquired into when he reaches home. Those who have heard of it here have expressed considerable indignation at this and other things which are reported of him. If what is asserted of him be true he may well be disciplined by his local Society. If it be erroneous, an explanation from him would probably be appreciated by his colleagues who are here.

While on the subject of the choice of the place for the next meeting, I may say, that this one has been marked by a degree of good-feeling which it is pleasant to note; and, so far as Philadelphia is concerned, there is apparently a complete restoration of the peace between it and the Association, which was of late so disturbed. The invitation which was not accepted was fully appreciated, and I have no doubt it would have been accepted if this had rested with the Association instead of the Nominating Committee.

Friday, May 11.

This was the closing day of the meeting; and, as usual, there was a comparatively small attendance. The business was hurried through; a few attempts were made to get in special resolutions; and an adjournment was effected after the passage of a hearty vote of thanks to Dr. Garnett for the admirable manner in which he has presided over the meeting. This resolution was not a mere form; for the proceedings this year have been entirely orderly and decorous, and have presented a marked contrast to certain others which it might seem invidious to specify.

One of the interesting episodes of the closing hours of the meeting was the introduction of a resolution by an ex-President of the Association—who is said to be a stockholder in a large manufactory of pharmaceutical preparations—that hereafter there should be no exhibit of pharmaceutical and surgical appliances. The reason given for presenting this resolution was that the exhibits distract the attention of the members of the Association from its own business. Certain of the unbelieving here have been so irreverent as to connect the resolution of the ex-President with the fact that the firm, with which he is said to be associated, has no exhibit here.

I cannot say how all these things may be; but this episode contributed materially to the interest of this meeting, and gave rise to some very amusing speeches. The outcome has been that the Association voted down the ex-President's resolution and pronounced most emphatically in favor of exhibits, and the exhibitors go away rejoicing.

So closes what has impressed me as a very successful meeting of the Association. Much good work has been done and I think I have seen the promise of much more to come. As you requested me to limit my correspondence as much as possible to the social and administrative features of the meeting, I have said very little about the scientific proceedings; but I may state in closing, that they appear to me to have been of unusual excellence. This I find is the general opinion, so that the meeting at Cincinnati is likely to be memorable in every way.

Yours truly, J. C. B.

—Dr. Henry Mitchell, State Inspector of the Board of Health, of Asbury Park, has resigned from the local board, of which he was President for eight years. The Borough Commissioners have passed a series of resolutions regretting the doctor's retirement.

PERISCOPE.

Etiology of Floating Liver.

In the *Berliner klin. Wochenschrift*, No. 38, 1887, H. Rosenkranz reports the case of a woman, forty-eight years old, who was at the climacteric and had had eight normal births. In the middle of February, 1887, she was suddenly taken sick with violent vomiting and pain in the pit of the stomach and around the liver. Soon afterwards ascites, oedema of the limbs, genitalia, and skin of the belly occurred. The urine was free from albumin, the heart normal, and there was no jaundice. Through the administration of diuretics and hydragogue cathartics, the ascites and oedema soon disappeared. The general feeling of the patient was good. In May the abdominal cavity was found by repeated examination to be filled with a large tumor, which from its form and mobility was recognized without difficulty as the liver. The gall bladder and all the lobes of the liver could be plainly felt on palpation. The normal area of liver dulness had disappeared. It was now easy, says Rosenkranz, to explain the ascites and oedema. The violent vomiting had effected the separation of the liver from the diaphragm, and hence the violent pain at that spot. The absence in this case of pendulous abdomen is especially noteworthy.—*Centralblatt f. d. med. Wissenschaften*, April 14, 1888.

Boldine, a New Hypnotic.

The glucoside boldine, which is contained in boldo leaves, is said, by French experimenters who have studied it, to have hypnotic properties. It is easy to take, has no bad after-effects, increases the appetite and at the same time strengthens the patient. Doses of seventy-five and one hundred and fifty grains were administered to different patients by Juranville daily, without injury resulting. The sleep which is induced is like natural sleep, and respiration is regular and quiet. Excited, hysterical and other nervous patients who had suffered for a long time with sleeplessness, sank into a refreshing, quiet slumber under the use of boldine. It is given in capsules containing three grains, or hypodermically dissolved in water.—*Deutsche med. Wochenschrift*, April 19, 1888.

Diseases of the Aortic and Mitral Valves of Long Duration.

At a meeting of the Clinical Society of London, January 27, Dr. J. Kingston Fowler described this case, which was that of

a man 66 years old, a wood-turner, working a treadle lathe. Physical examination of the chest gave the following results: There was a systolic recession of the epigastrum; the cardiac apex was in the fifth interspace in the nipple line; the impulse was forcible, indicating a moderate degree of hypertrophy of the left ventricle; at the apex the first sound was accompanied by a systolic murmur; at the base, in aortic area, there was a short systolic *bruit*, and the second sound was replaced by a rough diastolic murmur; there was evidence of some hypertrophy of the right ventricle; the valves on the right side of the heart were judged to be competent. The pulse was 84, small and collapsing. The urine was free from albumin. The interest of the case centred in the fact that in 1834 the patient, then a boy aged 13, was admitted into the Middlesex Hospital, under Dr. (afterwards Sir) Thomas Watson, with acute rheumatism, for which he remained under treatment nearly nine months. During the early part of the illness leeches were applied to the praecordium on more than a dozen occasions, and subsequently blisters were frequently used. The evidence upon which it was concluded that the valve lesions now present occurred during the attack of acute rheumatism in 1834 was entirely circumstantial, no written evidence of the case having been found. It might be summarized as follows: 1. The statement of the patient that on a certain occasion two gentlemen accompanying Dr. Watson on his visit, having auscultated the patient's chest, the one remarked that he heard a sound "like an old woman blowing a bellows in a back room;" the other said the sound was more "like to the whistling of a steam engine." 2. The fact that Dr. Watson told the patient's mother on his discharge from the hospital that he was never to leave home without telling her where he was going. 3. That for three years the patient carried a card with his name and address upon it, so that "if anything happened to him suddenly it might be known who he was and where he lived." 4. That he had had no return of the rheumatic attack, and had scarcely been absent from work for a single day during the last fifty-four years. The case was reported as being a rather remarkable example of a stationary lesion of the cardiac valves of rheumatic origin, in which compensation having been established, it had remained perfect for fifty-four years, and now showed no signs of failure. The patient had been shown at a previous meeting of the Society.—*British Med. Journal*, February 4, 1888.

Use of Pessaries.

Dr. Wallace A. Briggs, in a paper read before the Sacramento Society for Medical Improvement, February 21, 1888, says that pessaries must always be regarded as foreign bodies and their irritating qualities reduced to a minimum. This is to be accomplished: 1. By using thick, polished, non-absorbent pessaries. A rough absorbent surface not only irritates mechanically but also furnishes conditions extremely favorable to decomposition and consequent chemical irritation and even septic infection. A pessary with thin bars is much more likely to abrade and perforate the vaginal walls and to interfere with the pelvic circulation than one with thick bars. 2. By educating the vaginal mucous membrane and the neighboring tissues to a tolerance of the pressure, friction, and other causes of irritation consequent on the use of pessaries. This may be done by the use of either antiseptic cotton or antiseptic lamb's wool support. Either of these materials, indeed, but especially the latter, on account of its elasticity, makes an admirable pessary. Previous to packing, astringents, either in powder or in solution, may be applied to the vagina for the purpose of "hardening" it. Some prefer the use of elastic pessaries to test the tolerance of the pelvic tissues. He has not, however, found them altogether free from objection, and ordinarily prefers the antiseptic packing. 3. By accurate adjustment. By no means should the instrument be too large, otherwise the vagina will be unduly distended, irritated, inflamed, eroded, perhaps perforated, and the functions of neighboring organs seriously interfered with. Accurate adjustment relates to form as well as to size. Sharp angles should be regarded with suspicion, if not altogether discarded. One should never attempt to accomplish too much with the first pessary. 4. By occasional, sometimes frequent, removal of the pessary. In this way we obviate the evil effects of continuous pressure. In properly selected cases, therefore, instruct the patient to remove the pessary every third or fourth night on going to bed, and to introduce it again in the morning before rising. In the interval, position may be relied upon to keep the uterus in place. 5. By thorough cleanliness secured by daily cleansing and occasional antiseptic irrigation of the vagina.

Not only, he says, must pessaries be regarded as foreign bodies, but their contraindications must also be kept well in view. To the neglect of these, he thinks, must be ascribed much of the prevailing doubt as to the value of pessaries. Among these contra-

indications may be mentioned fixation of the displaced uterus; either acute, subacute, or some forms of chronic inflammatory affections both of the uterus and of the uterine annexes. Minor contra-indications consist of catarrh and erosions of the cervix, excessive weight of the uterus whatever its cause, extreme flexibility of the uterine walls, and vaginitis.

The author closes his paper with notes of several cases illustrating the benefits which accrue from the use of pessaries in appropriate conditions.—*Sacramento Med. Times*, April, 1888.

Treatment of Loose Cartilage in Knee-joint.

At the meeting of the Harveian Society of London, February 2, 1888, Mr. Herbert Allingham reported a case in which he had sutured the internal semilunar cartilage of the knee to the head of the tibia. The patient was a man, 35 years old, who had been constantly laid up by the slipping of the internal fibro-cartilage of the knee-joint. An incision two inches long was made, with its centre over the cartilage. The knee-joint was opened, and a strong catgut suture passed through the fibro-cartilage and the periosteum of the upper end of the tibia. The joint was washed out with carbolic lotion, and the synovial membrane united with deep catgut sutures; the wound was then closed without drainage. The patient, who was shown to the Society, made a good recovery, and can now follow his employment.—*British Med. Journal*, Feb. 11, 1888.

Pulsating Pleurisy.

A. Keppler, in an article in the *Deutsches Archiv für klin. Med.*, XLI, Heft 3, states that most of the cases of pulsating pleurisy occur on the left side; in a case of Eichhorst's, however, the pleurisy was on the right side. Keppler believes that the condition which occasions the phenomenon is brought about in the first place by a paralysis of the intercostal muscles, which is especially apt to occur in purulent pleurisy. Other factors in its development are a certain pressure under which the exudation exists, which is conditioned especially by sacculation of the latter; and finally, a sufficient power in the movements of the heart. Of course, an airless lung placed between the heart and the exudate is especially adapted to the unaltered propagation of the pulsating movements. As the pulsations are for the most part general, they are differentiated in this way from the pulsations occasioned by aneurism.

THE
Medical and Surgical Reporter.
A WEEKLY JOURNAL,
ISSUED EVERY SATURDAY.

CHARLES W. DULLES, M. D., EDITOR.

Original Contributions will be paid for when published; or 200 reprints will be furnished in place of payment, if a request is sent with the manuscript.

The Terms of Subscription to the serial publications of this office are as follows, payable in advance:—

Med. and Surg. Reporter (weekly), a year,	\$5.00
Quarterly Compendium of Med. Science,	2.50
Reporter and Compendium,	6.00
Physician's Daily Pocket Record,	1.25
Reporter and Pocket Record,	6.00
Reporter, Compendium and Pocket Record,	7.00

All letters should be addressed, and all checks and postal orders drawn to order of

Drs. RANDOLPH & DULLES,
 N. E. Cor. 13th and Walnut Streets.
 P. O. Box, 843. Philadelphia, Pa.

A correct statement of the circulation of THE MEDICAL AND SURGICAL REPORTER is published in each number. The edition for this week is 6,500 copies.

THE AMERICAN MEDICAL ASSOCIATION.

The thirty-ninth annual meeting of the American Medical Association which has just been held in Cincinnati was one which may justly be a source of satisfaction to all the friends of the Association. The scientific proceedings included important papers and discussions by men from all parts of the country, and were unusually full and interesting. The subjects ranged from those of the broadest and most general interest to those of minute and special detail. One of the most valuable addresses was undoubtedly that of the President, Dr. Garnett, who gave a clear picture of the present state of medical education in the United States, and urgently recommended the adoption of suitable legislation to regulate medical education by State authority, and to confine the right to issue licenses to practice to State Examining Boards. The details of this address include some points in regard to which there may be some difference of opinion; but the general principles of it can hardly be dissented from.

Other subjects of general interest were introduced and discussed by other members of the Association. For example, there was an important discussion on pneumonia, in the Section on Medicine, and a sort of symposium upon inflammation at and near the vermiciform appendix, in the Section of Surgery; and a very remarkable paper and experimental demonstration by Dr. N. Senn in regard to determining the fact and location of perforations of the intestinal tube in cases of gunshot wound of the abdomen. The Section on Obstetrics and Diseases of Women was largely attended, and its work of the most instructive and interesting character. The same may be said of almost all the sections, while especial mention might be made of the work accomplished in the new Section on Dermatology and Syphilography.

These departments of the Association all showed a high degree of activity, and demonstrated their great usefulness. In the general meetings very little besides routine work was done. The business of the Association was transacted smoothly and satisfactorily. The most interesting subjects considered were probably the conduct of the Journal of the Association, and certain proposed amendments to the Constitution which provide for placing a large part of the administrative business of the Association in the hands of a permanent committee. The latter proposition was laid over for further consideration until the next meeting. The former subject was not discussed openly, although it was very warmly discussed outside of the meeting.

The general affairs of the Association seem to be in good condition. The discord which has so recently exercised an unfortunate influence upon the prospects of the Association seems to be fast disappearing. Some parts of the profession which have been alienated from the National Society appear to have determined to let the past go, and come back loyally to the Association, while the Association itself seems willing to give them a hearty welcome. At no recent meeting has so little of the unfortunate influence of agitation been apparent; and at

none has there been so strong evidence of the good sense and warm hearts of the members of the profession all over our land.

In looking over the whole of this meeting, we feel that there is every reason to congratulate the Association and the members of the medical profession in general, upon the cementing of friendship and advancement of scientific knowledge which it has brought about; and we may look forward with bright hope to the future, expecting the American Medical Association to be—as its originators designed it to be—the chief agent in developing unity of sentiment and increase of scientific attainment among the members of the medical profession in America.

A POINT IN REGARD TO INSANITY AND ITS TREATMENT.

The daily papers of May 1, 1888, report the fact that a clergyman who committed suicide at White Plains, N. Y., on April 29, had some time before confessed to his physicians that he was suffering with melancholia, and had an almost irresistible impulse to shoot himself. It appears, also, that he had already once made an attempt to take his own life, and that his father and brother had committed suicide.

This painful occurrence calls attention to the importance of having persons afflicted with melancholia under adequate surveillance, so that they may not have opportunity to carry out the insane impulses to which they are so peculiarly liable. It is a fact well known to alienists that persons afflicted with melancholia are apt to pass with frightful rapidity from a state in which they suffer with mere depression of spirits into one in which they become dangerous to themselves or to others. Occurrences similar to that mentioned above are so common that it seems utterly inexcusable for physicians to neglect to insist that the friends of persons who develop melancholia should adopt precautions adequate to prevent them. It may at times seem almost cruel for medical men to tell the friends of those under their care that nothing but the restraint of a hospital

for the insane can be relied on to save a person with melancholia from doing violence to himself or to others; and yet there is no other way to prevent such catastrophies as must have come under the observation of almost every medical man.

Fortunately, in these days the fictitious horrors of insanity are being dispelled, and it is coming to be regarded as a true disease, which is often amenable to judicious treatment; and subjection to the discipline of a hospital for the insane is not now-a-days regarded as an incarceration. It is not nearly as shocking as it once was to propose this plan of dealing with those whose minds are unbalanced, and medical men should encourage the further growth of a rational sentiment in regard to insanity by showing that they regard it as a disease, and do not shrink from suggesting what they know to be the only reliable means of dealing with it.

By taking a proper attitude toward this whole subject, and making their opinions known to the community, medical men may do a great service to their fellow-men, not only by making it easier when the occasion arises to apply these opinions, so as to avert a threatening disaster, but also by bringing others to regard diseases of the mind with less distress and despair. The ways in which a more rational appreciation of the condition called insanity may be of value to those who suffer with it, as well as to their friends, are too numerous to be mentioned here; but we commend the subject to the reflection of our readers, in the hope that they will give it careful thought, and see if it does not suggest a distinct opportunity of usefulness to their fellow-men.

THE HOUSETOPI AS A HEALTH RESORT.

The suggestion to utilize the roofs of city houses as a place of escape from the noise and unwholesome conditions of the street-level is by no means a new one. It has been not only made before now, but also acted on; and several large cities have popular resorts high up above the level of the ground, and to be reached only by steam elevators. But, lately Dr. Gouverneur M. Smith, of New

York, has proposed that the roofs of city houses shall be systematically occupied, for the sunlight and fresh air which can be there obtained, and has urged the devising of some plan by which it can be made feasible.

This proposition is one which deserves attention. Unfortunately Dr. Smith makes no suggestion of a plan himself, and no plan has ever been suggested which is of general applicability in the climate of a large part of our country. So, it is hardly likely we think that the day will ever come when a city in the United States shall have its roofs comparable to those of the towns of Syria, which are sometimes called cities. But, we believe something is attainable in the direction of utilizing the roofs for obtaining the benefits of light and air. Access to the roof of every house ought to be as easy as access to any part of it—of course with proper safe-guards against accident to children. In fact, the roof of a house ought to be a sort of pavilion, with a covering which would admit light and exclude the storm in winter, and give free access to the air when the weather is warm. To secure these objects a costly structure would be needed, one with a covering made in part of strong glass, and immovable, so that the sunlight could pass freely through it in winter, and in part of some material light enough to be removed in summer, and strong enough to bear a load of snow in winter. To modify the roofs of many houses now built so that they would fit this description would be very costly; and to construct new houses with such roofs would put a hard strain upon buyers and renters of houses, most of whom cannot afford a larger investment than will furnish them living rooms enough. But we believe it to be not only practicable, but also very desirable for those who can go a little beyond their absolute necessities to make use of the opportunities for light and air which are afforded by their roofs. In winter they could be used as solariums, in summer as refuges from the heat, and in every season they might afford a most delightful place of recreation and amusement.

We commend this idea to the attention of

our readers in the hope that some of them may be able to suggest a plan by which they can be carried out.

IMPREGNATION AFTER CASTRATION.

A question which has most interesting physiological aspects, and may have an important forensic bearing is: whether, or not, a man who has had his testicles removed has still, for a moderate length of time, the power of impregnating a woman. This subject has been discussed at different times by a few students of physiology and of medical jurisprudence; but it has never been absolutely settled. The natural presumption is that under these circumstances a man would not be able to impregnate a woman. But—strange as it may seem—this is by no means certain. On the contrary, as the Roman author, Varro, claims to have known an instance in which a castrated bull impregnated a cow, so there are some medical writers who claim that a castrated man may impregnate a woman. The most recent writer on this subject is Dr. N. Obolonsky, prosecutor in the University of Charkow, Russia, who discusses it in the *Viertel-jahrsschrift für gerichtliche Medicin*, April, 1888, principally in connection with a curious set of fanatics called "Skopzen" in that country. These fanatics practice castration as a part of their duty; but are not thereby prevented from indulging in great sexual excesses.

Obolonsky has studied the subject alluded to historically and experimentally, and finds no reason to doubt that, for perhaps a month after removal of the testicles, spermatozoa may be present in the vesiculæ seminales, and may be ejaculated in sexual intercourse. The historical part of his study is interesting enough; but more interesting and more conclusive is his report of the results of experiments he made upon two dogs, which showed that living and active spermatozoa were found in one seven days after castration, and in the other a month after the date of this operation. Obolonsky points out the fact that there is no reason for supposing that the same thing might not occur in a man; and em-

phasizes the importance of this possibility in a medico-legal sense.

It would be extremely interesting if this line of study were taken up and followed out by some American investigator, and an attempt were made to learn for how long a time after castration living spermatozoa could be detected in the seminal ducts or vesicles of animals; and also whether or not sexual excitation would cause their ejaculation. It is not likely that the results of such a study would prove of frequent applicability to actual medico-legal questions; but there is no telling when this very improbable occurrence might take place. Meanwhile, the matter would be of great physiological interest, and might throw a useful side light on other and commoner aspects of the phenomena of sexual intercourse and reproduction.

CATHETERIZING THE MALE URETERS.

One of the boldest suggestions in the line of surgical diagnosis which we have ever seen comes recently from AXEL IVERSEN, of Copenhagen, who in the *Centralblatt für Chirurgie*, April 21, 1888, proposes the operation of supra-pubic cystotomy and catheterization of the ureters, as a means of determining which kidney of a man may be affected with pyelitis. In making this proposal, Iversen points out the importance of being able to ascertain which of the two kidneys is affected in any case, and the unreliability of the methods hitherto used for this purpose. In women it is not very difficult to catheterize the ureters through the urethra; but in men this is impossible. Last January Iversen had a patient with supposed calculous pyelitis, upon whom he thought it desirable to do a nephrectomy, or a nephrotomy. Being unable to ascertain in any other way which kidney was affected, he performed supra-pubic cystotomy, and catheterized both ureters. The result of this investigation showed him which kidney was affected with pyelitis, but it also satisfied him that no further operation was advisable, and he abandoned the idea of doing either a nephrectomy or a nephrotomy, as he had intended. The cystotomy wound healed

satisfactorily, and the patient was none the worse for the diagnostic operation.

Iversen is so satisfied with the result obtained in this case that he declares that he would毫不犹豫地 repeat the procedure in a similar case, and expresses the opinion that supra-pubic cystotomy is by no means a dangerous operation, especially when performed for a diagnostic purpose.

There can be little doubt that supra-pubic cystotomy is an operation which, when carefully and skilfully performed, is not so dangerous as to preclude its employment for the purpose proposed by Iversen; and there seems to be sufficient justification for resorting to it when no other measure furnishes the information necessary to decide which of two kidneys shall be operated upon, when an operation on one seems to be necessary. As yet it has not been practiced often enough in this country to make it appear so simple an operation as it appears to Iversen; but its merits are understood well enough to prevent his conduct and recommendation from seeming to be rash.

QUACK ADVERTISEMENTS IN RELIGIOUS NEWS-PAPERS.

It is pleasant to observe that our editorials in regard to the abuse of the columns of religious newspapers by the insertion of advertisements of quack medicines have not fallen to the ground without effect. From different parts of the country we have received communications which indicate not only that our comments have met with the approval of our professional brethren, but also that they have been taken to heart by some of those at whom they were directed. Among others, we note that the *California Christian Advocate*, a Methodist paper, endorses what we have said, and stigmatizes quack advertisements in religious papers as an abomination. The editor adds that he rejects many advertisements, but that they are not usually submitted to him and he is not responsible for the business.

We regret that this should be the case; for we feel sure that if it were otherwise, the

paper which he edits would not illustrate the practice which he deplores. But, even as it is, we are glad to see in him an ally in a cause which we believe to be a worthy one, and which needs friends among the clergy. We have no doubt that there are many editors of religious papers who feel, with the editor of the *California Christian Advocate*, the mortification of having their names associated with papers which publish unblushing falsehoods, and we believe that if they wish they can soon end their troubles. Indeed we are sanguine enough to expect that they will do this, and to look to them with a good hope as well as good wishes.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

DISEASES OF THE SKIN. A MANUAL FOR PRACTITIONERS AND STUDENTS.
By W. ALLAN JAMIESON, M.D., F.R.C.P.Ed., Extra Physician for Diseases of the Skin, Edinburgh Royal Infirmary, etc. With woodcut and eight colored illustrations. 8vo, pp. xiv, 546. Edinburgh: Young J. Pentland. Philadelphia: J. B. Lippincott Company, 1888. Price, \$6.50.

This volume gives a clear exposition of the subject which it treats from an English standpoint. The author's ideas show the marked influence which the teachings of Hutchinson and Unna have had upon dermatology. The plan of the work is essentially that adopted in books of its class.

In regard to the natural oiling of the hair, the author considers that Liebreich's researches on lanolin lead to the conclusion that the hair itself secretes a cholesterol fat and is thus kept pliant. If this deduction is warrantable, it would raise the hair, as Jamieson states (and evidently accepts), to the position of a living structure, and the reported cases of sudden blanching, would not be necessarily either impossible or miraculous. The statement is made also, based evidently upon Unna's investigations, "that not only the papilla, but all the interior of the follicle, as far as the opening of the sebaceous gland duct, is capable of producing the hair." If this be confirmed it would, of course, have some bearing in the destruction of hair by electrolysis. In this operation a desideratum hitherto considered desirable has been the insulation of the end of the needle, so as to limit the electrolytic action to the papilla, and thus reduce the chances of scarring to a minimum; but according to the above view of the hair growth, such insulation, were it possible, would be a positive disadvantage. In describing the operation here referred to the author draws largely from the writings by G. H. Fox. The interrupter in the handle of the needle-holder, as suggested by Unna and here advised, is in our judgment not to be commended, being a disadvan-

vantage both to the operator and to the patient. When the current is thus broken there is always too much risk of disagreeable shocks, and these about the head are, it is needless to add, extremely unpleasant, and may in fact be even dangerous.

The name of "molluscum contagiosum" is retained, the author holding the common English view of its contagiousness. Herpes progenitalis is looked upon, in the majority of cases at least, as a sequela of some antecedent venereal disease, apparently through some persistent nerve irritability. This is in accord with Unna and Greenough—the correctness of the view we are, however, by no means willing to admit. To us a more rational explanation of its apparent frequency in those addicted to venereal pleasures is that in such individuals the slightest irritation about the genitalia excites solicitude, and a physician is consulted; whereas in those of correct habits this condition would probably give rise to no anxiety, passing away in a few days and thus escaping medical observation. In respect to Duhring's "dermatitis herpetiformis" the following appears: "Our acquaintance with cutaneous diseases will require to be more extensive and more precise before we can accept conclusions so sweeping as his; but the cases put on record are most valuable, and sooner or later will lead to more accurate knowledge." The colored illustrations, as is almost invariably the case in the text-books, are, in an artistic sense, poor, and do not add to the general excellence of the volume.

In the matter of therapeutics the author's views while sufficiently advanced are sound and conservative.

CORRESPONDENCE.

Old and New Treatment of Pneumonia.

EDITOR MED. AND SURG. REPORTER:

Sir :—Acknowledging, with thanks, the notice in the REPORTER of my recent paper on Pneumonia, allow me to say further to your readers that my purpose was not specially to advocate venesection, but to contrast the results of the now current method of treatment, which I characterize as stimulation and narcotism, with the practice of forty years ago, in which sedative and eliminative measures were used, among which local and, less often, general bloodletting has been proved to have positive value. My conclusion, based on observation and experience, and confirmed by statistics, is given as follows: "There is more room for question, on the basis of experience, between the treatment of forty years ago and pure expectancy, nursing the patient in bed without medication, than there is between the old practice and that which is now generally current."

Yours truly,

H. HARTSHORNE.

Germantown, Philad'a.,

May 4, 1888.

NOTES AND COMMENTS.

Faecal Accumulation.

Dr. Julius Wesselowski, reports a case in the *Kansas City Med. Index*, March, 1888, in which a woman, forty years old, had been feeling bad for about two weeks. The patient had a peculiar ashy countenance, and a temperature of 103° ; the tongue was coated, and the breath foul. She said her bowels moved every day, but not enough, although she had taken calomel, senna, jalap and salt. On examining her abdomen, he found it largely distended with gas and a very prominent lump in the right side of the body. After manipulating carefully, as even the slightest touch would produce indescribable pain, he made out a large accumulation of faecal matter in the ascending colon. He injected into the bowel at first two ounces of glycerine every hour, and gave an injection of soap and water every hour. After six hours of hard work, he noticed that the lump, by easy manipulation, became softer and friable. The first good movement the patient had was in about seven hours after his arrival. As soon as she had a movement, which consisted of hard lumps containing graham flour and raspberry seeds, which she had eaten about two weeks before, she became easier. The gas passed off, and the temperature fell to 99° . The next day he learned that she had about six more movements during the night and morning. He examined her again at that time and found that the whole lump had disappeared. In a few days she was well. He advises never to give a purgative of any kind while the faecal impaction exists.

Cocaine and Loss of Vitreous in Cataract Operations.

Dr. A. D. Williams says: As I have heretofore stated, the greatest benefit we get from the use of cocaine in operating on cataracts is the almost entire prevention of the loss of vitreous. Before the introduction of cocaine the greatest anxiety in cataract operations was the ever-present fear of rupture of the hyaloid membrane and loss of vitreous. Cocaine prevents this accident in an indirect way. It kills sensibility, and thus prevents all muscular action. In this way the patient is prevented from squeezing the vitreous out by violent muscular contraction. While killing the pain of the operation is a grand thing, the resulting or secondary effect is the greatest boon. Since using cocaine the loss of vitreous has been the rarest exception. Only very recently I operated on an old man in the usual way.

The lens was easily delivered. In manipulating the cornea for the purpose of clearing the anterior chamber of all particles of lens substance, suddenly and unexpectedly a bead of vitreous popped up. I had to desist to allow the remains of the lens to be absorbed away. Had there been no cocaine used in this case the loss of vitreous would certainly have been "frightful," and very likely destructive. The patient made a rapid recovery and had a good result. This, so far as I remember, is the first loss of vitreous I have had since using cocaine.—*St. Louis Med. and Surg. Journal*, 1888.

Remarkable Tolerance of Bullet Wound of the Brain.

It is reported in the *Philadelphia Ledger*, April 21, from Owingsville, Ky., that a man named A. G. Owings, who had been shot on the 7th inst., died on Thursday from the effect of that wound. The ball from a 38-calibre pistol struck Owings in the forehead between the eyes, and penetrated to a depth of five inches. Owings felt so little inconvenience that, thinking the ball was only below the skin, he did not send for the doctor to remove it until the following Monday. In probing, the doctor extracted about a spoonful of brain, but did not find the ball. Still Owings felt but little pain, ate and slept as usual, and attended to his work until the morning of the day he died. He then, after a deep sleep, sank into a stupor, in which he died.

Formula for Migraine.

Dujardin-Beaumetz recommends:

Tincture of gelsemium..... $\frac{3}{4}$ ijij
Simple syrup..... $\frac{1}{2}$ viij

M. S. Dose—One tablespoonful three or four times a day.

Hydrofluoric Acid in Phthisis.

At glass factories the beneficial influence of hydrofluoric acid on tuberculous workmen has long been noted, and many attempts have been made to employ this agent in the regular treatment of phthisis. M. Garcin has cured thirty-five and relieved thirty cases out of a hundred by means of this acid; ten of the hundred died, and in fourteen there was no improvement. The patients sit for one hour a day in an atmosphere saturated with hydrofluoric acid. This saturation is effected by passing a current of air by means of a pump through a tank of gutta-percha containing nine and one-half ounces of distilled water, and three-fourth ounces of hydrofluoric acid.—*Lancet*, February 4, 1888.

**Abscess in Bulbous Portion of Urethra
Following Gonorrhœa.**

At the meeting of the Sacramento Society for Medical Improvement, Feb. 21, 1888, Dr. G. L. Simmons, Jr., reported a case in which an abscess in the urethra had formed four weeks after the appearance of the discharge. The patient, a young man, had used one of the many patent injections, and with entire success as he supposed, until he noticed a swelling just under the pubic arch. The discharge at that time had almost ceased. This swelling, which was accompanied by severe pain and fever, compelled him to seek medical aid. The injection was stopped, cold applications to the perineum ordered, and an antipyretic internally. An anodyne suppository was found necessary to control the pain at night. Though the acute symptoms moderated the swelling increased until the entire penis became three times its natural size, congested and resistant along its entire length, and the foreskin, which was naturally quite redundant, was painfully distended. Micturition was difficult. The least chordee was insufferable to the patient, and the strength of the anodyne was doubled to counteract the pain. Poultices, as hot as could be borne, were applied, when it became certain that the formation of pus could not be arrested. Under this local treatment, with quinine and iron internally, and opium by the rectum, the abscess broke on the tenth day. The opening was evidently in the bulbous portion of the urethra, as there were no symptoms connected with the neck of the bladder. The purulent discharge was quite free. The patient's general health continued remarkably good throughout the whole course of the abscess formation, and with the evacuation of the pus all the minor symptoms disappeared. At no time was there any vesical irritation or prostatic trouble. Under a mild injection, the gonorrhœal symptoms which had again declared themselves, readily yielded. At the date of this report, one month from the time of the rupture of the abscess, Dr. Simmons says that there remains an infiltration about the bulbous portion of the urethra, which causes the penis to be somewhat bowed during vigorous erection. With this single exception his condition is perfect.—*Sacramento Med. Times*, April, 1888.

•••••
Pathogeny of Iodoform Delirium.

At the meeting of the Academy of Medicine of Paris, March 20, M. Jeannel made an interesting communication on the "Pathogeny of Iodoform Delirium." The appli-

cation of iodoform produces, he says, unimportant or serious effects according to the state of the patients. Each time delirium has occurred in a wounded person treated with iodoform, M. Jeannel proved that the patient had suffered from an antecedent cerebral affection, either alcoholism, chronic meningitis or mental derangement. His observation enabled him to conclude that, (1) a wound on an individual not suffering from a constitutional infirmity, may be dressed with iodoform; (2) this may also be done if the patient be not suffering from a constitutional affection not cerebral; (3) iodoform applied to a wound on a patient affected with a cerebral constitutional malady, produces delirium of greater or less intensity.

Galezowski's Antineurapeutic Formula.

The Paris correspondent of the *Pharmaceutical Record*, gives the following formula:

Menthol.....	gr. xii
Cocaine.....	gr. iv
Chloral.....	gr. ii
Vaseline.....	gr. lxxv]

M. Ft. Unguentum. Sig.—Apply to the painful parts, and cover with muslin.

It is said to be especially useful in periorbital pains and in ophthalmic hemicrania.

Medical Society of the State of New Jersey.

The one hundred and twenty-second annual meeting of the Medical Society of the State of New Jersey will be held in the Heath House, Schooley's Mountain, on Tuesday and Wednesday, June 12 and 13. Treasurers of District Societies are requested to send the amount of dues of their respective Societies to Dr. W. W. L. Phillips, Trenton, on or before June 11. Abundant space has been provided for exhibitors of surgical instruments. There will be a complimentary banquet in the Heath House, Tuesday evening at 10 o'clock, to the delegates and visitors. Dr. John G. Ryerson, Boonton, N. J., is Chairman of the Committee of Arrangements. A very interesting series of papers and discussions is on the programme.

Celebration in Honor of Dr. Hiram Corson.

Dr. Hiram Corson, of Conshohocken, Pa., was given a complimentary banquet, April 25, by the Montgomery County Medical Society, in honor of his sixtieth anniversary in the active practice of medicine. Dr. J. K. Weaver presided. A number of distinguished physicians from all parts of the State were present. After the banquet and some preliminary remarks by Dr. Weaver, the latter called upon Dr. P. Y. Eisenberg to

respond to the toast "Our Honored Guest." In the course of his address he referred especially to the debt which the profession owed Dr. Corson for his advocacy of the treatment of inflammatory diseases and acute infectious diseases with cold.

In Dr. Corson's reply he referred to the early days of his career, and to the many men of mark of a former generation whom he had known. Speaking of the country as it was in his earlier days, and of the methods of travel, he said :

"To me, then a mere stripling, there was at the time of which I speak no Ardmore, no Bryn Mawr in Lower Merion, no Bridgport in Upper Merion, no Collegeville, Zieglersville or Pennsburg on the banks of the Perkiomen, no Lansdale or North Wales, no Fort Washington or Ambler on the Wissahickon; and, above all, no Conshohocken, East and West, with their thousands of people. Norristown was a mere village, noted only for its small academy, its court-house and prison, and its two-horse stage which made daily trips to Philadelphia. Then the postage on a letter in Pennsylvania was 10 cents, but if it were to be sent "away off" to Ohio, twenty-five cents was demanded. There was scarcely a bridge, save on the turnpike roads, over the rapid and oft-times swollen Skippack, Perkiomen and Wissahickon creeks, and even the Schuylkill river had to be passed through the water at its various fords, by the physicians in their rides by night as well as by day, and often at the risk of life. Dr. McLean, who practiced in Horsham earlier than the persons already named, was drowned while fording the Wissahickon below Reiffs mill. Physicians generally rode on horseback. For years I crossed the Schuylkill river at Matson's Ford—the present site of Conshohocken bridge—oft-times when the cold, almost freezing water came far up the horse's sides. Patients were widely separated and physicians were rarely able to see even their acute cases oftener than every other day. Consultations were rare. However fiercely death assaulted, we were compelled to confront him alone. Sorely did I feel this necessity, and how great was my relief when I could have the counsel of an experienced physician! In this isolated way, we worked along for many years."

On January 17, 1847, the Montgomery County Medical Society was permanently organized, and owes its present success largely to the untiring energy and zeal of Dr. Corson.

Following Dr. Corson's reply, there were a number of short speeches by the different physicians who were present.

NEWS.

—Dr. Joseph Bauer has been appointed Professor of Clinical Medicine in the University of Munich.

—Dr. C. S. Muscroft, of Cincinnati, died suddenly in that city, May 5. He was at one time President of the Cincinnati Academy of Medicine.

—Dr. Straus has been appointed successor to the late Prof. Vulpian as Professor of Experimental and Comparative Pathology in the Faculty of Medicine of Paris.

—Dr. C. D. Palmer, of Cincinnati, was seriously injured, May 6, by being thrown from his carriage while his horse was running away. It is feared that his injuries may prove fatal.

—The prize offered by the *Pharmaceutical Era* for the best essay upon the Mutual Relations of Physicians and Pharmacists, has been awarded to Prof. F. H. Gerrish, of Bowdoin College.

—In the *Boston Med. and Surg. Journal*, May 3, 1888, Dr. John Homans reports a case of ovariotomy for multilocular papilloma in a woman eighty-two years and four months old. He states that not a single case of ovariotomy in women eighty years of age or older had been previously reported. His patient recovered.

—The Camden County Medical Society held its annual meeting at Gloucester City, May 8, Dr. Gross presiding. Officers were elected as follows: President, W. H. Iszard; Secretary, E. L. B. Godfrey; Treasurer, A. M. Mecray; Board of Censors, Drs. John W. Snowden, H. G. Taylor, J. R. Stevenson, Alexander Marcey and H. E. Brannon. Delegates were also elected to the various conventions and national associations. At the dinner which followed, Dr. H. Genet Taylor was presented with a silver set as a testimonial of services of a quarter of a century as Secretary.

—A bill has been introduced into the Legislature of New York which provides that "it shall not be lawful for any person or persons to introduce into or upon any dead body of any person or human being any poisonous substance, organic or inorganic, for the preservation of the same, or any so-called embalming fluids or materials of any kind, which will, in any manner whatsoever, interfere with chemical tests which may subsequently be applied or made use of by chemists in medico-legal investigations."

HUMOR.

ETHEL USED TO PLAY A GOOD DEAL in the school class. One day she had been very quiet. She sat up prim, and behaved so nicely, that after the recitation was over the teacher remarked: "Ethel, my dear, you were a very good little girl to-day." "Yes'm. I couldn't help being good. I got a tiff neck."—*Presbyterian Banner*.

A REMARKABLE CASE OF HEREDITY.—A correspondent of the *N. Y. Medical Journal*, April 28, 1888, writes that a hydrocephalic child was born to an ultra-prohibitionist father, who said to the doctor:

"What is the matter with my child?"

"Why, it has inherited its disease from you."

"What do you mean?"

"Why, it has water on the brain."

THE *Ft. Wayne Medical Journal* indulges in the following aient microbes:

Some M. D.'s are downright skeptics,
Devoid of faith in antiseptics,
The very name of microbe hate,
The chief of whom is Lawson Tate.

To this the *Medical Standard* adds: This is the most severe cut Tait has had to endure; nobody previously had ventured to insinuate that he was a microbe.

NEW DRUG CLERK—"Beg pardon, sir, but that young lady who just went out asked you for infant powder." Old druggist—"Yes." "But you gave her regular face powder." "Yes; I always make that mistake. That's how I got up such a big trade. If a woman really wants infant powder she will insist upon having it."—*American Hebrew*.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the two weeks ended May 5, 1888:

P. H. Bailhache, Surgeon, to proceed to New York, N. Y., for temporary duty, May 1, 1888.

W. H. H. Hutton, Surgeon, detailed as President of Board to report as to quarantine establishment at North Chandeleur Island, Gulf of Mexico, May 4, 1888.

Walter Wyman, Surgeon, granted leave of absence for fourteen days, May 4, 1888.

G. W. Stoner, Surgeon, detailed as Chairman of Board for the physical examination of candidates for appointment and promotion, Revenue Marine Service, May 5, 1888.

F. W. Mead, Passed Assistant Surgeon, detailed as Recorder of Board for the physical examination of candidates for appointment and promotion, Revenue Marine Service, May 4, 1888.

H. R. Carter, Passed Assistant Surgeon, detailed as Recorder of Board to report as to quarantine establishment at North Chandeleur Island, Gulf of Mexico, May 4, 1888.

S. C. Deeven, Passed Assistant Surgeon, relieved from duty at Sapelo Quarantine; to assume charge of the service at Savannah, Ga., May 3, 1888.

J. H. White, Passed Assistant Surgeon, relieved from duty at Savannah, Ga.; to assume charge of Sapelo Quarantine Station, May 3, 1888.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from May 6, 1888, to May 12, 1888:

Lieutenant-Colonel James C. McKee, Surgeon, granted leave of absence for one month. S. O. 107, A. G. O., May 9, 1888.

Major Charles R. Greenleaf, Surgeon; Major Robert M. O'Reilly, Surgeon, and Capt. John O. Skinner, Assistant Surgeon, detailed as members of a board of medical officers to assemble at the U. S. Military Academy, West Point, N. Y., on June 1, 1888, to examine into the physical qualifications of members of the graduating class and of the candidates for admission to the Academy. S. O. 104, A. G. O., May 5, 1888.

Par. 11, S. O. 104, A. G. O., May 5, is amended by Par. 4, S. O. 108, A. G. O., May 10, 1888.

Major Charles R. Greenleaf, Surgeon; Major Robert M. O'Reilly, Surgeon, and Capt. John O. Skinner, Assistant Surgeon, are detailed as a board of medical officers to assemble at the U. S. Military Academy, West Point, N. Y., on June 1, 1888, to examine into the physical qualifications of the candidates for admission to the Academy, and, in connection with the Superintendent of the Academy and Commandant of Cadets, the members of the graduating class.

Major Harvey E. Brown, Surgeon, the leave of absence for seven days granted by orders 68, Fort Barrancas, Fla., May 2, 1888, is extended twelve days. S. O. 90, Div. Atlantic, May 8, 1888.

Capt. Leonard Y. Loring, Assistant Surgeon, granted leave of absence for three months on surgeon's certificate of disability. S. O. 105, A. G. O., May 7, 1888.

Capt. Paul R. Brown, Assistant Surgeon, granted leave of absence for six months, on surgeon's certificate of disability, with permission to leave the Division of the Atlantic. S. O. 107, A. G. O., May 9, 1888.

Capt. Robert B. Benham, Assistant Surgeon, to proceed from Du Chesne to Fort Douglas, Utah, and report to commanding officer of that post, not later than 25th inst., to accompany Battalion of 6th Infantry to Fort Lewis, Col. Upon completion of this duty, will return to his station, Fort Du Chesne, Utah. S. O. 33, Dept. of the Interior, May 5, 1888.

Changes in the Medical Corps of the U. S. Navy for the week ending May 12, 1888:

Passed Assistant Surgeon A. G. Cabell, detached from "Adams," and to proceed home and wait orders.

Surgeon M. H. Simons, detached from Naval Academy, and to Practice Ship "Constellation."

Medical Director P. J. Horwitz, leave of absence for six months to leave the United States.

A Naval Medical Examining Board is now in session at the Naval Hospital, Philadelphia, for the examination of candidates for admission to the Medical Corps of the Navy. There are eleven vacancies in the list of Assistant Surgeons. Permits for examination can be obtained on application to the Secretary of the Navy.